INVESTIGATION INTO THE ADMINISTRATION OF PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICA WITH SPECIFIC REFERENCE TO THE EMFULENI LOCAL AUTHORITY

by

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SUMMARY

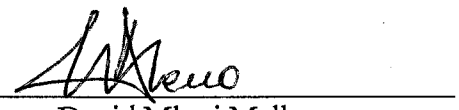
Primary health care represents a change from curative approach to preventive approach to rendering health care services. The study analyses the problems encountered in the administration of primary health care in South Africa with specific reference to the Emfuleni Local Authority. The study describes the role of international institutions in the administration of primary health care in South Africa. Furthermore, the historical development, the role of the National Department of Health in the administration of primary health care services is outlined. The study also investigates the role of the Gauteng Provincial Department of Health regarding the implementation of district health system, health promotion, the involvement of the private sector and NGO's in primary health care. Problems encountered by the Emfuleni Local Authority such as lack finance, personnel shortages, security, urbanisation, non-involvement of traditional healers and citizen apathy are investigated. Lastly, governmental relations for primary health care are described.

KEY TERMS

Primary health care
Services
Administration
South Africa
Gauteng Province
Emfuleni Local Authority
District health system
Health promotion
Citizen participation
Governmental relations

DECLARATION

I declare that "INVESTIGATION INTO THE ADMINISTRATION OF PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICA WITH SPECIFIC REFERENCE TO THE EMFULENI LOCAL AUTHORITY" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

This chapter serves as an introduction to the dissertation on an investigation into the administration of primary health care services in the Republic of South Africa (South Africa) with specific reference to the Emfuleni Local Authority. In addition, it provides the scope and the logical development of the argument in this dissertation. It therefore focuses on the statement of the problem concerning primary health care, objectives with the study, significance of the study, research methodology, reference techniques, restrictions on the study, terminology, phenomena and abbreviations, sequence of chapters, and finally the summary.

The approach of the study is depicted in diagram 1, on page 2. This diagram shows that the study focuses on international, regional, sub-regional international health institutions, the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. It implies that attention will be paid to problems experienced in the above-mentioned institutions. The reason for selecting the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare is because most primary health care services in Gauteng Province are rendered at these spheres of government. Moreover, the proximity and problems encountered by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare further necessitated focus. In addition, the Gauteng Provincial Department of Health and Emfuleni Department of Health and Welfare were selected because their areas of jurisdiction are densely populated as a result of urbanisation sparked by the search for employment. Urbanisation requires the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare to identify problems related to primary health care and then address them within their limited resources. It is for this reason that this study focuses on problems encountered in the administration of primary health care services in the aforementioned

areas.

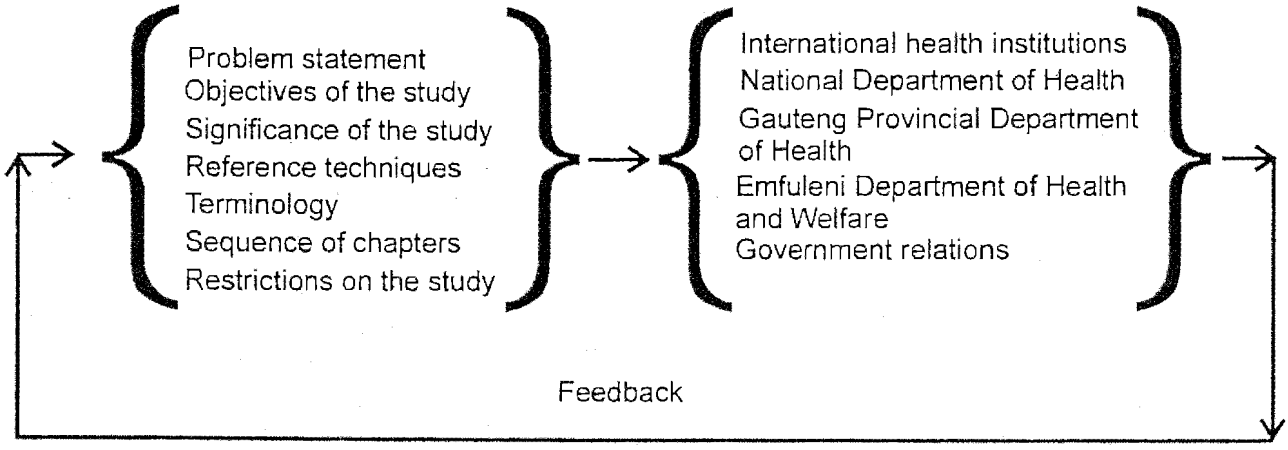


Diagram 1: Analytical framework for the Study

1.2 STATEMENT OF THE PROBLEM

The administration of primary health care services is an integral part of the broader administration of all services rendered by public institutions. The administration of primary health care services, like other public services, requires the sparing utilisation of amongst others financial resources since the health needs of an ever-increasing South African population are increasing, while the majority cannot afford the cost of private medical health care. Moreover, the capacity of the population to pay additional percentages of their incomes on taxation is not increasing. The South African health authorities are none the less, expected to improve the quality of primary health care services and the health status of all the citizens. Problems encountered by the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare in the rendering of primary health care services are the focus of this dissertation. Where applicable notice will also be taken of the problems encountered by the international institutions, regional international institutions and the sub-regional institutions or their inputs as well as governmental relations in primary health care. Furthermore, in an attempt to identify and solve these problems, this dissertation focuses on the administration of primary health care

services as it forms the nucleus of the delivery of such services.

Problems, which have been identified in the aforementioned areas of the study, are as follows:

- Inaccessible primary health care services in informal settlements. The National Department of Health, in its White Paper for the Transformation of the Health System in South Africa, admits that the health services are fragmented and unevenly distributed, resulting in inefficiency and ineffectiveness. In particular, many people in rural and peri-urban areas have inadequate access to health care services. (South Africa 1997a: 205.)

- An increase in the number of patients. Simon (1997:10) reported that the introduction of free primary health care in Gauteng Provincial Department of Health led to the increase of patients that clinics had to deal with (Madonsela 1999). The increase of patients leads to the increase of operational costs in primary health care services. On the contrary, the Gauteng Provincial Government's R3, 8 billion health budget for the 1996/7 financial year was 10% below the previous financial year (that is, 1995/6) (Duffy 1996:6).

- Unevenly distributed and fragmented primary health care services. The South African Government, through its adoption of the Reconstruction and Development Programme (RDP) in terms of the White Paper on the Reconstruction and Development and subsequent relevant legislation in 1994 committed itself to an efficient and accessible primary health care programme (African National Congress 1994:8). However, despite all good intentions and commitments, numerous problems are still experienced in the administration of primary health care. These problems are among others the relatively heavy concentration of resources (financial and personnel) within some of the hospitals and the consequent under-resourcing of primary health care services (South Africa 1996a: 2) at for instance clinics.

- The granting of severance package to skilled personnel. The granting of severance packages is a result of the transformation plan of the government, which was negotiated with the unions

such as Public Servants Association and the National Education and Health Allied Workers Union in March 1997. The aim of this plan was to create a leaner, more efficient public service within three years by shedding 300 000 jobs either through voluntary retrenchments or by doing away with vacant posts and granting large pay increases to key skilled personnel such as doctors and nurses. For this plan to have worked, 100 000 jobs including those in the administration of primary health care would have had to be scrapped in 1997. Instead, only 19 000 applications for retrenchments have been approved. Although another 79 000 vacant posts existed, departments and provinces have resisted attempts to have them scrapped. (Paton 1997:1.)

- The government has consequently wasted R1-billion on a programme to trim the civil service (Hartley 1997:2). This programme led to the loss of the best personnel by amongst others, the National Department of Health and the Gauteng Provincial Department of Health. The attempt to trim the public service has further damaged the financial management capacity of the government. The plan failed because "the wrong personnel had applied". Most personnel who applied for the voluntary severance packages were skilled personnel in strategic positions. The Cabinet subsequently decided to end the offer of voluntary severance package on 31 March 1997. The Minister of Public Service and Administration also admitted that the voluntary severance offer had failed (Hartley 1997: 2).

- As a result of the said transformation plan, a number of hospitals in Gauteng Provincial Department of Health underwent major conversions and changes. The conversions and changes resulted in some hospitals serving as day clinics only (Discoverers in Roodepoort, Hillbrow, Lenasia, Johan Heyns in Vanderbijlpark, Laudium, Germiston and Nigel hospitals), while some were closed (Westfort and Andrew McCallum in Pretoria and Kempton Park) (Duffy 1996:6). The Gauteng Provincial Department of Health in October 1996 announced the transformation plan. The transformation plan received widespread criticism from unions, staff members and the community, all dissatisfied because they had not been consulted during the process. The plan set out to restructure hospitals because of the inequalities of resources and

staff-to-patient ratios inherited from the previous government. It was also found that certain hospitals such as Johan Heyns were under-utilised.

The announcement regarding the restructuring of some and closure of other hospitals had a negative impact on service delivery. The said announcement affected personnel morale badly because personnel were uncertain about the future. As a result of uncertainties stemming from relocations and transfers, an exodus of skilled personnel from institutions designated for downgrading or closure took place. (Singh 1997:16.) Consequently, the departure of such skilled personnel may have a negative impact on the effectiveness and efficiency of the administration of primary health care.

- misuse of financial resources. Approximately R30 billion was spent on health care in South Africa in 1992/93. This is equivalent to 8.5 percent of the Gross Domestic Product (GDP), or one twelfth of the economy (South Africa 1996a: 1). South Africa spends R550 per capita (per person) per annum on health care. This is nearly ten times what the Bank of Reconstruction and Development (World Bank) estimates it should cost to provide basic public health services and essential clinical care for all in developing countries, yet millions of people in South Africa are without such service (African National Congress 1994:23). South Africa is thus devoting substantially more resources on the health sector than most developing countries, yet has a poor health status relative to these countries. This implies that there is a dire need to find solutions to the above-mentioned problems that impede accessibility of primary health care services. The disparity between the amount of money budgeted for health and the health status of South Africans further suggests the existence of problems in the administration of primary health care services.

Furthermore, in terms of section 195(b) of the *Constitution of the Republic of South Africa Act, 1996 (Act 108 of 1996) (Constitution of the Republic of South Africa Act, 1996)*, the administration of each state department should ensure that the utilisation of resources is efficient, economic and effective. Similarly section 27 of the *Constitution of the Republic of South Africa Act, 1996*

provides that everyone has the right to have access to health care. It is through the adherence to the foregoing two sections and other related sections of the *Constitution of the Republic of South Africa Act, 1996* that the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare have a responsibility for the administration of primary health care as one of their objectives.

- Theft of medical supplies and equipment. The theft of medical supplies and equipment denies members of the public their right to have access to health care (Madonsela 1999) and places an extra burden on the taxpayer.

- Inadequate community participation in policy-making for the administration of primary health care services (Madonsela 1999).

It was against this background and the situation outlined in the foregoing paragraphs that it was decided to investigate the nature and extent of the aforementioned problems in the administration of primary health care services. The focus will however, not be on South Africa as a whole as the scope for such an investigation will be too comprehensive for purposes of this dissertation. Therefore, the investigation is restricted to the National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health and Welfare as well as governmental relations in the administration of primary health care between the above mentioned institutions. Cognisance will also be taken of the influence of international institutions in the field of primary health care.

1.3 OBJECTIVES WITH THE STUDY

In view of the foregoing statement of the problem, the objectives with this dissertation are:

- to describe the impact of international health institutions on problems encountered in the administration of primary health care services in South Africa,

- to find a solution to the problem on the inadequate access to primary health care services,
- to make suggestions on how to increase the capacity of clinics to deal with an increased number of patients as a result of free primary health care,
- to address the problem of misuse and insufficient resources,
- to find ways to stop or minimise the theft of medical supplies,
- to report on an investigation into problems associated with the closing down of some hospitals,
- to discuss the positive and negative impact of granting severance packages to personnel,
- to determine the reasons and solutions to low public participation in policy-making regarding primary health care, and
- to recommend practices which can lead to the effective and efficient administration of primary health care.

1.4 SIGNIFICANCE OF THE STUDY

The significance of this study is to investigate the nature and extent of the foregoing problems in the National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health and Welfare, the related governmental relations and the possible solutions to overcome or prevent them. This implies that all the succeeding chapters describe the existing problems as outlined in the objectives in the administration of primary health care services.

Findings and recommendations based on the said problems and objectives with the study are therefore presented at the end of this dissertation. In this way, the output of this study may contribute to public administration as a field of work (by providing readers with possible solutions to existing problems in primary health care) and study by increasing the literature on the subject.

1.5 RESEARCH METHODOLOGY

The data for this research can be classified into primary data and secondary data. The nature of these two types of data is explained hereunder.

Primary data: The collection of primary data is also known as empirical investigation.
This investigation involves consulting primary information sources. It comprises of;

- interviews with experienced and knowledgeable officials in the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare, and
- speeches by politicians and deliberations in legislative institutions (as documented in Hansard)

Secondary data: It refers to the collection and the analysis of existing written (published and unpublished) information. It includes:

- published books on this subject,
- published articles,
- current legislation and bills (acts of Parliament, provincial and local legislation, green papers and white papers),
- journals,
- documentation by international institutions concerned with primary health care in South Africa such as the World Health Organisation (WHO), and
- official documentation by the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare on the

administration of primary health care services.

The data obtained from the secondary sources will be compared to, and be evaluated against the data from primary sources in order to support the arguments presented in this dissertation.

In this dissertation, the survey method is used for data gathering techniques and the normative approach is adopted for the processing of data. According to Leedy (1989:141), the word survey is composed of two elements that indicate precisely what happens in the survey process. Sur- is a derivative of the Latin word super, meaning "above", "over", or "beyond"; the element - vey comes from the Latin verb videre, "to look" or "to see". Thus, the word survey means "to look or to see over or beyond" the casual glance or the superficial observation.

The foregoing exposition implies that a survey study is conducted in which the "looking" may be done by means of interviews. The study also poses a normative approach to the question "what should the true state of affairs be?" which implies some projection of value judgements on to reality.

1.6 REFERENCE TECHNIQUE

In a scientific report it is common practice to use references for drawing the attention of the reader to something important that would otherwise disturb the train of thought in the text. In this dissertation the Harvard method is used. According to Du Toit (1992:11), this reference method allows the reader to read reasonably uninterrupted while the information sources are still clearly indicated. Two aspects of this method were of particular importance in the writing of this dissertation, that is the use of references in the text and the compiling of a list of sources.

When the Harvard method of referring to other works is used, the reference to sources (both monographs and articles) is not shown in footnotes but between brackets in the text. Thus a citation from the work of a single author would, for example, be followed by stating between

brackets the author's surname, year of publication, colon and the number(s) of the page (s), for example (Du Toit 1992:12).

Some of the requirements regarding the list of sources in the case of the Harvard method are as follows:

- Books - Author's surname, comma, author's initials, full stop, ed. (In the case of an editor), date of publication, full stop, complete title of the book (underlined), full stop, place where published, colon, publisher (abbreviated), full stop.
- Articles - Author's surname, comma, author's initials, full stop, year of publication, full-stop, title of article (not in inverted commas and not underlined), name of publication (underlined) comma, volume, number, comma, first to last page numbers of the article, full stop.

Furthermore, Burger (1992:28) states that the list of sources should be arranged alphabetically according to surnames of the authors. The foregoing principle is applied in this dissertation with a view to enable the reader to connect a reference in the text with an item in the list of sources.

1.7 RESTRICTIONS ON THE STUDY

This dissertation is presented with the framework of public administration and more specifically concentrates on the administration of primary health care in the international, regional, and sub-regional international health institutions, the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. The unfolding of arguments throughout the succeeding chapters, therefore concentrate on the administrative side of primary health care. This means that the study focuses on administrative functions performed in the rendering of primary health care services. The administration of primary health care services requires the identification of problems for purposes of policy formulation. Furthermore, administration cannot take place if funds have not been allocated to

departments of health at the three spheres of government. For this purpose, the specific areas investigated are the international, regional and sub-regional health institutions, the National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health and Welfare and governmental relations.

In the case of an international sphere of primary health care administration, this dissertation focuses on the impact of the activities of international health institutions on the administration of primary health care services in South Africa and particularly on the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. Apart from the focus on universal health and other related institutions, the regional sphere of primary health care administration includes only institutions on the African Continent because of their proximity and ability to make suggestions regarding the solutions to problems encountered by South Africa and other countries in the administration of primary health care. Furthermore, at provincial and local spheres of the administration of primary health care services, only the Gauteng Provincial Department of Health and the Emfuleni Departments of Health and Welfare are considered.

1.8 TERMINOLOGY, PHENOMENA AND ABBREVIATIONS

Terminology is the study of terms. To ensure that the terminology, phenomena and abbreviations in this dissertation are understood, general terminology and abbreviations are explained below. More specific terms, phenomena and abbreviations, which need explanation, are explained within each chapter.

1.8.1 Administration

According to Cloete (1986:1), administration is to be found where two or more people take joint action to achieve an objective. However, in an attempt to achieve objectives in the administration of primary health care, problems outlined in section 1.2 of this chapter occur. An objective to be achieved by administration could, for example, be the rendering of primary health care services

in the Gauteng Province. The foregoing definition of administration is too broad because it may also refer to administration in the private sector. Administration within this context refers to the functions (that is, policy-making, policy implementation, policy evaluation, feedback, financing, organising, personnel, work procedures and control) undertaken by the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare in order to render primary health care services to members of the public and thereby promoting the general welfare. The term administration makes more sense when used in conjunction with the word "public" which according to Fowler, Fowler and Thompson (1995) refers to anything open or shared by all the people. The term public also refers to all people within the area of jurisdiction of the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. In addition, Graham and Hays as quoted in Stillman (1992:2) define public administration as a generic expression for the entire group of activities that are involved in the formulation and implementation of public policies.

1.8.2 Corruption

Corruption means the misuse or unethical use of a public office for private gain. Elements of corruption within the context of this dissertation are:

- the theft or embezzlement of public funds aimed at the improvement of the administration of primary health care services and
- theft of medical supplies and equipment.

The corruption of public officials by private interests is usually very subtle: favours by the public to the official put the official under obligation and he/she gradually substitutes his/her public loyalties to those doing him/her favours (Hanekom, Rowland & Bain 1993:154).

1.8.3 Transparency

The term transparency is composed of three elements, which help in understanding it. "Trans" means across or through, the element "par" is a prefix while "ency" is a suffix denoting a quality or state (Fowler, Fowler and Thompson 1995). The term transparency therefore refers to a state where members of the public could see through the activities of for instance the departments of health.

The government of the day has declared its activities to be transparent. Transparency in the National Department of Health, Gauteng Provincial Department of Health and Emfuleni Department of Health and Welfare is further enhanced by the democratic principles (such as the government which is based on the will of the people) on which the South African government is based. Moreover, the fact that the administration of primary health care services forms part of the broader administration of public services implies that in a democratic country like South Africa, the activities of public institutions must be subjected to scrutiny by the voters-cum-taxpayers. However, members of the public will only be able to scrutinise the efficient administration of primary health care services if there is transparency in the performance of public activities. Transparency therefore means that everything that a public authority does should be observed, investigated and judged. That is the reason one speaks of public administration. (Cloete 1996:75.) In other words, the activities of the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare should, wherever possible, take place in the open rather than be shrouded by a veil of secrecy.

Transparency further means that those who observed or investigated the administration activities should have the right and freedom to express their views on the matter; in other words, they should have freedom of speech which includes the freedom to write and publish their views and consequently also include the freedom of the press. (Cloete 1996:75.) This freedom of speech, freedom to write and publish is also applicable to primary health care activities on the three spheres of government.

Although section 195(1)(g) of the *Constitution of the Republic of South Africa Act, 1996* states that transparency must be fostered by providing the public with timely, accessible and accurate information, it still have some limitations. Information is normally made available only when the authorities feel that it is in the "interest" of the public. In some instances information is not made available because it may cause confusion. The budget on the administration of health services, for example, is not made available for scrutiny by members of the public until a specific day in March. This implies that although the government of the day claims to be transparent and democratic, there will always be circumstances under which the information may not be made available for strategic reasons. For example, the publication of the health budget immediately after it has been consolidated by the Department of Finance, may raise expectations regarding the expenditure which is still subjected to changes by the Cabinet and approval by Parliament.

1.8.4 Policy

Policy refers to a plan of action approved by the national, provincial or local legislative institutions for implementation by administrative executive institutions such as the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Departments of Health and Welfare. Furthermore, policy can also be said to be an approved statement of intent to do something or to have it done by specified institutions or functionaries as prescribed (Cloete 1996:92). An example of a policy statement is the Health Act, 1977 (Act 63 of 1977).

1.8.5 Policy-making

Policy-making means the process of formulating a policy. The suffix "ing" in policy-making implies that there is continuity in the policy-making process. It could, therefore, be said that there is a need for policy-making in the absence of a policy (that is, to formulate a new one) and in the presence of a policy (to adapt the existing one). In addition, policy-making is referred to as a process because it involves a number of activities, for example, the identification of a dysfunctional

situation, research and ascertaining of the views of members of the public and rigorous debates by legislative institutions before approval.

1.8.6 Primary health care

Primary health care refers to a comprehensive care that includes curative, preventative, promotive and rehabilitative care within the context of, amongst others, community participation and inter-sectoral collaboration (South Africa 1995a: 73). Primary health care depends on community participation because this approach to health tries to involve the community in the prevention of diseases rather than waiting for cures.

According to the World Health Organisation (1988: 15), primary health care is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work. This effort of bringing primary health care services closer to the people require among others, the availability of financial and human resources.

According to Fowler, Fowler and Thompson (1995:1085) the word "primary" refers to something which is fundamental or of first rank in a series. The word "health" refers to the state of being well in body and mind. The combination of the two words, therefore, refers to the rendering of primary health care services for the physical and psychological well being of all members of the public, particularly those who cannot afford services rendered by private medical health institutions.

In addition to the foregoing definitions, it is important to point out what primary health care is not:

- it is not primary medical care because it emphasises prevention. On the contrary, primary medical or curative care is the assessment (history taking and physical examination) as well as a specific care or treatment, of a patient. This is only one aspect of primary health care;
- it is not the only first contact medical health care because it precedes medical health care (medical health care only comes into the picture of health if preventive care fails. Primary health care is concerned with educating the community about ways to prevent diseases);
- it is not only health services for all because health services for all includes both primary health care and curative care. Primary health care is more than health facilities and personnel. It has to be made an integral part of community development for it to succeed;
- it is not cheap, simple or second-class care. There is a misconception that hospital or high technology care is first-class medicine and that any other form of health care is inferior. The success of primary health care lies in a comprehensive approach based on meeting the basic needs of the people that will enable them to lead healthy life styles. The co-ordination and planning for this broad approach are complex, not cheap and are based on the findings of scientific research, which involves many disciplines. (Dennil, King, Lock and Swanepoel 1995:3.)

Similarly, it is also necessary to point out what primary health care is and what it does:

- it is intended to reach everybody, particularly those in greatest need;
- it is intended to reach to the home and family level, and not to be limited to health facilities;
- it is intended to involve a continuing relationship with persons and families. (World Health Organisation 1988:16.)

Examples of primary health care services are, among others, personal and preventive services; health education; communicable, non-communicable and endemic disease prevention and control;

school and institutional health services for children; community nursing and home care services; and health services support which include epidemiology and health information system, health monitoring, planning and administration. (South Africa 1997a: 38).

1.8.7 Abbreviations

AU - African Union
AIDS - Acquired Immune Deficiency Syndrome
ANC - African National Congress
GDP - Gross Domestic Product
HIV - Human Immuno Deficiency Virus
PHC - Primary Health Care
RDP - Reconstruction and Development Programme
SADC - Southern African Development Community
UN - United Nations
WHO - World Health Organisation

1.9 SEQUENCE OF CHAPTERS

Chapters in this dissertation are arranged in terms of their relatedness. They are horizontally and vertically linked. This implies that the theme of each chapter is related to other chapters and the title of the dissertation. The following sections explain the sequence and progression of the chapters of the dissertation.

CHAPTER 1

Introduction

This chapter serves as an introduction and puts the dissertation into perspective. It provides a

background to the problem, objectives with the study and outlines the significance of the research, research methodology, restrictions on the study, terminology, and the sequence of chapters.

CHAPTER 2

International perspective on primary health care

This chapter focuses on international, regional and sub-regional health and related institutions with a view to determining the impact of their activities on the National Department of Health, the Gauteng Provincial Department of Health, and the Emfuleni Department of Health and Welfare.

CHAPTER 3

National perspective of primary health care services

Chapter three focuses on the historical background of primary health care in South Africa, the role of the National Legislature and the National Department of Health in solving problems related to policy, financing, personnel and other matters related to primary health care.

CHAPTER 4

Primary health care service with specific reference to the Gauteng Provincial Department of Health

This chapter concentrates the role of the Gauteng Provincial Department of Health in the administration of primary health care services. To fulfil its role, The Gauteng Provincial Department of Health implements the district health system and use approaches such as the medical approach, behavioural approach, educational approach, empowerment approach and social change approach in health promotion. Furthermore, chapter 4 describes corruption, the role of the private

sector and non-governmental organisations in the administration of primary health care in the Gauteng Province.

CHAPTER 5

Primary health care services provided by the Emfuleni Local Authority

Like the foregoing spheres of government, the Emfuleni Department of Health and Welfare plays a significant role in the administration of primary health care services. The focus of this chapter is on problems encountered by the Emfuleni Local Authority. Furthermore, this chapter describes the role of hospitals and clinics, finance, personnel, security, urbanisation, traditional healers and community participation in the administration or rendering of primary health care.

CHAPTER 6

Governmental relations in primary health care

In South Africa co-operation and co-ordination is expected within and between the three spheres of government. Governmental relations and its role in facilitating the effective administration of primary health care between the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare is the main theme of this chapter.

CHAPTER 7

Summary, findings and recommendations

In the final chapter a summary, findings and recommendations relating to problems outlined at the beginning of this chapter and further expanded on in the succeeding chapters are presented.

1.10 SUMMARY

The foregoing chapter serves as an introduction to the dissertation. It puts the dissertation in perspective by stating the problem of this research, objectives with the study, its significance, research methodology, restrictions on the study, clarification of the terminology, phenomena and abbreviations used, and the sequence of chapters.

CHAPTER 2

INTERNATIONAL PERSPECTIVE ON PRIMARY HEALTH CARE

2.1 INTRODUCTION

The establishment, development and proliferation of international health institutions is a result of the inability of individual member states to be self-sufficient in finance and knowledge required to satisfy, among others, primary health care needs. The focus of this chapter is on the direct and indirect influence of the activities of international health and related institutions such as the WHO on the administration of primary health care services in South Africa. Mention is made of the National Department of Health in South Africa with a view to explain its influence on the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. In order to ensure efficient and effective co-ordination and co-operation between the institutions involved in primary health care attention will be given to governmental relations to achieve this.

Furthermore, attention is paid to the nature of international health institutions. These institutions are classified into three categories. The first category deals with international institutions such as the UN, WHO, the International Hospital Federation and the Commonwealth of Nations. The second category focuses on international-regional institutions such as the AU. International sub-regional institutions such as the SADC fall under the third category. The relationship between South Africa and the aforementioned health and related institutions pertaining to primary health care is also described.

2.2 INFLUENCE OF INTERNATIONAL HEALTH INSTITUTIONS ON PRIMARY HEALTH CARE IN SOUTH AFRICA

To understand the nature of international health and related institutions, it is necessary to explain the phenomenon international institution within the context of this dissertation. The word

"**international**" is a combination of two elements which are **inter** (among or mutual) and **national** (pertaining to the nation). From this it can be deduced that international primary health care services administration refers to primary health care activities among and mutual to all nations. Institutions responsible for the administration of primary health care and related activities may also be referred to as supra-state institutions; supra meaning higher than or above the individual state. An example of such institutions is the WHO. The supra-state institutions are always established by agreement among states with the objective of obtaining co-operation. (Faba & Roos 1998:5.) This is also the case with most international health and related institutions.

Furthermore, it is important to consider factors that distinguish international health institutions from the national health institutions in South Africa. Faba and Roos (1998:5) mention the following factors that are also applicable to most international health institutions.

- All international institutions such as the WHO originate from agreements such as the declaration of the UN on 1 January 1942 by a number of member states. Agreements aim at the realisation of a number of primary health care objectives in the international or regional spheres such as Africa. These objectives included health for all that includes primary health care.

- Within each international health institution provision is made for the determination of policy in its composition. The policy-determination function of international health institutions always has political implications for national states such as South Africa. The participation of for instance South Africa in health policy determination function commits the country to comply with international policies when determining its own policies. The governing committee of the WHO is the World Health Assembly and is composed of political executive office bearers of the different member states (for example, the Minister of Health represents South Africa in the WHO).

- International health institutions must obtain ratification for their decisions and actions by the

legislative institutions of the national states in which they operate before they can act within the territories of the latter.

- The international health institutions are all dependent on the contributions from member states, other considerate non-governmental institutions and individuals for financing of amongst others their primary health care activities.

2.3 CLASSIFICATION OF INTERNATIONAL HEALTH INSTITUTIONS

International health institutions are classified in this section with a view to describe their functions in relation to the assistance that they can offer to the South African health system. The sphere of activity of international health institutions is usually restricted to an international area, international-regional or international-sub-regional area. The number of member states largely determines their jurisdictions. The foregoing classification helps one to distinguish between institutions that function in a number of continents, those which function within one continent (regional), and those which functions within part of a continent (sub-regional). Diagram 2 further depicts the relationship between South Africa and international institutions described in this chapter. According to this diagram, international health and related institutions can influence primary health care in South Africa directly or indirectly.

2.3.1 International health and related institutions

The inability of certain states to become self-sufficient in terms of resources, knowledge and skills related to primary health care services, necessitates co-operation. This co-operation is manifested in the establishment of institutions such as the UN and more specifically the WHO and the International Hospital Federation. Knowledge and skills shared at meetings, conferences and research projects organised by these institutions can impact positively on policies and ultimately on the administration of primary health care services in member states including South Africa.

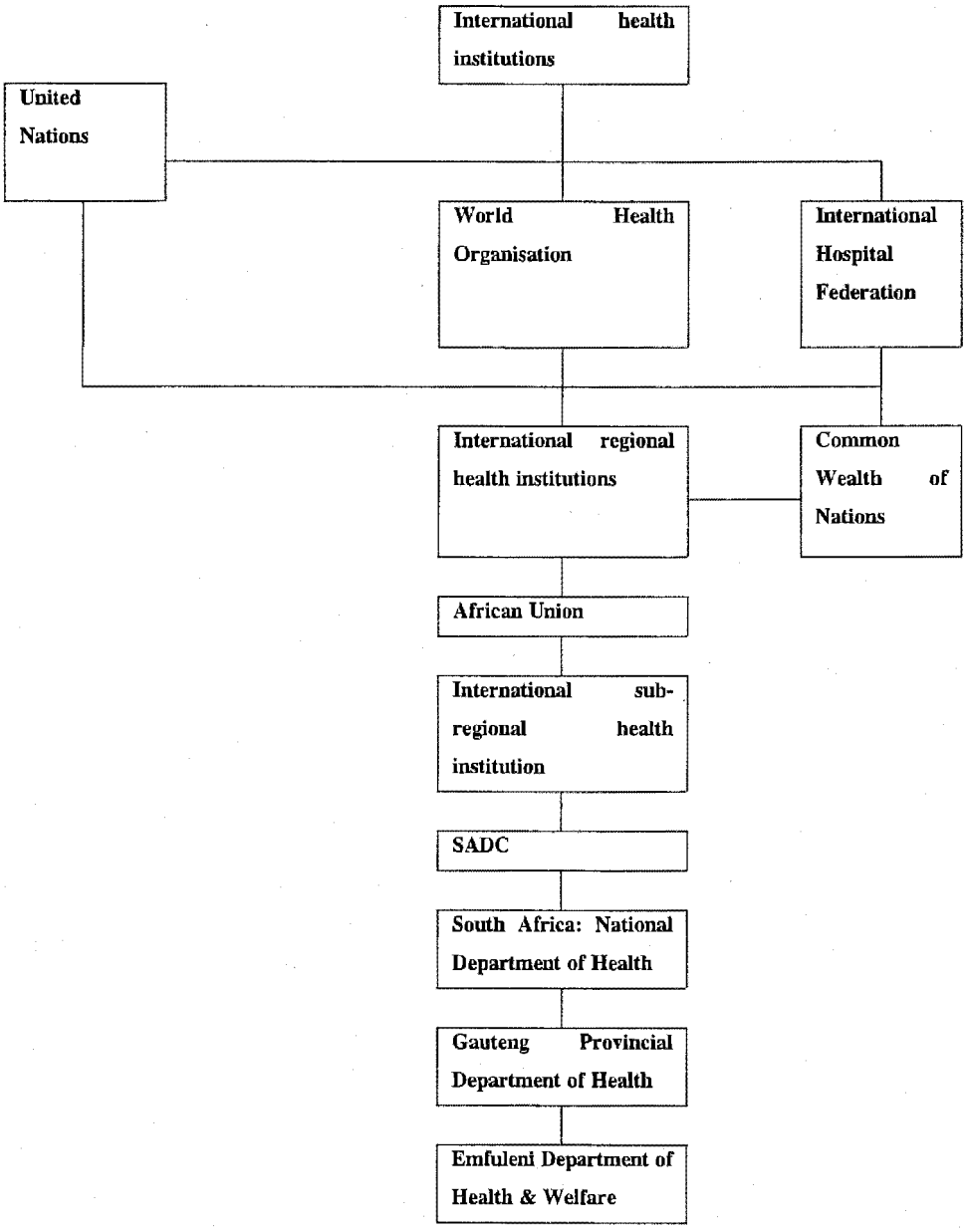


Diagram 2: Influence and relations between South Africa and international health and institutions

International health institutions play an important role in the administration of primary health care in a number of countries including South Africa. Other institutions, such as the Commonwealth of Nations, which may have an influence on the administration of primary health care, are also

considered.

2.3.1.1 Influence of the United Nations on primary health care in South Africa

This section of the dissertation focuses on the origin of the United Nations, its objectives and influence on South African primary health care services.

The UN, like its predecessor the League of Nations (League), emerged out of disagreements which were the result of the First and Second World Wars. The League failed to prevent the Second World War, but the desire remained for the establishment of an international institution able to settle disagreements between states amicably. The beginning of the Second World War did not put a damper on the desire to develop a successor to the League. Different states sought an institution that would prevent wanton human carnage and the concomitant massive waste in war actions. (Simons 1994:35.)

Soon after the outbreak of Second World War the Allied powers (that is, United States of America, Great Britain, Union of Soviet Socialist Republics and France) began their planning for the creation of the new international institution that would help to keep the peace. This ultimately led to the Inter-Allied Declaration on 12 June 1941 and two months later, to the Atlantic Charter (Simons 1994:35.)

The emergence of the UN had a positive impact on the strengthening of universal and regional health institutions. The WHO, for instance, is assisted by the UN in its endeavour to achieve its objectives that include amongst others primary health care. It is through peace and security established by the UN that most universal and regional health institutions were able to perform their functions, develop themselves and in turn contribute in solving the problems experienced by for instance South Africa and other member states in the administration of primary health care services.

In terms of Article 1 of the UN Charter, one of the objectives of the UN is to be a centre for harmonising the actions of nations with a view to attain common ends such as the prevention of

diseases through immunisation. Furthermore, Article 55 of the Charter commits the UN to create conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principles of equal rights and self determination of peoples. To achieve the foregoing objective the UN, among others, pursue the following issues that influence primary health care.

- Higher standards of living, conditions of social progress and development to prevent lifestyles which are vulnerable to diseases;

- Solutions of international health, and related problems (Padelford, Lincoln & Olvy 1973:562) such as the spread of AIDS. Such solutions are aimed at problems like the high patient to doctor ratio experienced by the South African National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare in primary health care.

Although the UN is not directly involved in the administration of primary health care services within the territories of member states, it does create favourable conditions under which member states can improve the quality of life and harmonise relations regarding primary health care between different countries. The UN can, for instance, co-ordinate and protects non-governmental institutions such as the Red Cross in their attempt to render primary health care services in countries where there are civil wars such as Angola. Furthermore, the UN Volunteers Programme for doctors can for instance help South Africa to recruit doctors for areas with the lowest patient to doctor ratio such as the Emfuleni Department of Health and Welfare's area of jurisdiction (South Africa 1996b: 55).

Furthermore, the UN has a number of specialised agencies such as the WHO and UNICEF which strengthen its effort and desire to assist. Among these agencies, the WHO can be of help to South Africa whenever the country is in need of assistance regarding solutions to problems such as the insufficiency of financial resources, which exist in the implementation of primary health care

services.

2.3.1.2 World Health Organisation (WHO)

The WHO emerged from a conference in July 1946 and came into being in 1948. The WHO is one of the specialised institutions formed outside the organisational structure of the UN, but which functions in close co-operation with the UN. The WHO has a number of regional offices in various continents. (Faba & Roos 1998: 14 & 20.) One of its regional offices is situated in Pretoria in South Africa.

According to Allen et al. (1997: 93) the World Health Assembly (Assembly) is the policy-making committee of the WHO. The Assembly meets annually in Geneva. It is responsible for the biennial programme which include primary health care, the budget, the appointment of the Director-General of WHO's secretariat, admission of new members and the review of budget contributions. Decisions, resolutions and declarations on primary health care such as the 1978 Alma- Declaration are taken by the World Health Assembly. This Declaration and the outcomes of the WHO's conferences are considered by the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare whenever they review policy on the administration of primary health care services as explained hereunder.

The South African National Department of Health introduced free primary health care services at public health facilities at all spheres of government (South Africa 1996b: 1). This is an attempt to comply with the Alma-Ata declaration that stipulates, amongst others, that all governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors. The Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare subsequently adopted the same approach. According to Zuma (1998: on-line), the reorientation of the public health system from a hospital based curative focus to a district based primary health care focus has been done with the direct assistance and funding by the WHO.

The Executive Board (Board) of the WHO assists in the implementation of agreements and resolutions taken by the World Health Assembly on, amongst others, primary health care issues. The Board is composed of 32 health experts designated by, but not representing their governments. They serve for a period of three years. The Board annually reviews its Director-General's programme, which it forwards to the Assembly with any recommendations that it may deem necessary. It also advises on questions referred to it by the Assembly. It is also empowered to take emergency measures in cases of epidemics or disasters that result in primary health care problems. (Allan et al. 1997:93.)

The WHO is a specialised agency that advises member states on public health, control and prevention of diseases. Furthermore, according to Faba & Roos (1998:14) the following are some of the WHO's objectives:

- the conduct of research and compilation of information about the occurrence of diseases anywhere in the world,
- the WHO also sees as its task the strengthening of primary health services rendered by the national and local departments of health, especially in Africa, Asia and Latin America, and
- the WHO was established with the objective of assisting people to attain the highest possible level of health. This implies not only physical health, but also social well being, and the elimination of diseases such as malaria, tuberculosis and aids (Faba & Roos 1998:20).

To attain the foregoing objectives, the WHO performs a variety of functions, which include, amongst others, the following:

- It acts as the central institution which directs international primary health care work like the immunisation of children against polio and hepatitis B (South Africa 1995b:55),
- the establishment of relations with professional groups such as Health Professions Council of South Africa (HPCSA) and the National Department of Health,

- it supports, on request from member states, programmes to train health workers best suited to the local needs and assists countries to strengthen their administration of national primary health systems and in developing their research capabilities which can help in solving problems related to primary health care, and
- according to the National Department of Health Annual Report (South Africa 1996b:57), the WHO donates money for projects on primary health care and environmental health.

Furthermore, the functions of the WHO are to:

- collect and disseminate health data about aids and malaria and carries out analyses and comparative studies on primary health care,
- promote improved environmental conditions, including housing, sanitation and better working conditions,
- encourage co-operation among professional groups and propose international conventions and agreements,
- develop an informed public opinion on matters of primary health and assistance in the strengthening of national primary health care services in, for instance, Africa. (Allan et al. 1997:94.), and
- provide fellowships and the facilitation of training courses, support national programmes aimed at preparing health workers best suited to local needs and resources. Specialists and advisory services are provided to assist in planning the health sector. Informed health officials can add to the effort to identify and find solutions to problems such as the spread of diseases within the area of this study.

The WHO promotes international strategies for the attainment of the main health target of member states: `health for all by year 2000', or the attainment by all citizens of the world of a healthy life (Allan et al. 1997:94). In May 1981 the World Health Assembly adopted a global strategy in support of this aim. Primary health care was, according to the 1978 Alma- Declaration, considered to be the key to `Health for all'. (Allan et al. 1997:94.) The Alma-Ata Declaration referred to above

outlines the commitment of various states to the improvement of primary health care services and the possible steps that may be followed to ensure that citizens of the world enjoy a healthy life. The declaration, among others, identifies education, individual and collective community participation in health matters, and the removal of inequalities in the health status as steps for the achievement of 'health for all'.

Allan et al. (1997:95) further point out that a division of Health Promotion, Education and Communication was established in May 1994 to implement the priority assigned to health promotion. Under the UN Special Initiative on Africa, launched in March 1996, the WHO was mandated to co-ordinate international efforts to secure improvements in the basic health care and to strengthen the administration of primary health care services and resources in Africa. In 1986 the WHO's Centre for Health Development was opened in Kobe, Japan. This centre researches health developments in for instance HIV/AIDS and other health determinants to strengthen decision-making within, for example, the primary health care sector relevant also to South Africa.

According to Luard (1994:78) the WHO co-ordinates research and information about the occurrence of diseases; runs a system for notification to communities in member states about various diseases, and for preventing their transmission. Furthermore, it helps developing countries such as South Africa to strengthen their own health services and to train doctors and nurses. It also improves developing countries' public health facilities and it launches World-wide campaigns against particular diseases, such as malaria and aids.

The training of doctors and other health officials may bring about improvements in the administration of primary health care services. Currently South Africa does not have enough doctors in the public sector hence the National Department of Health recruits medical doctors from Cuba. The Minister of Health indicated that the National Department of Health recruited 207 Cuban doctors in 1996 and that there were still plans to recruit more because of the need to provide primary health care services to all people who were previously deprived of such services (Hansard, 2-13 September 1996,1929). In addition to the assistance offered by countries such as Cuba, the

assistance provided by the WHO needs to be doubled in the training of doctors and nurses since they are also involved in the administration and rendering of primary health care services. The training of more doctors in South Africa will enable the country's public health sector to be self-sufficient.

2.3.1.3 International Hospital Federation

The International Hospital Federation (IHF) is an independent non-political institution supported by subscribing members in 90 countries. According to Masobe and Seritsane (1998), most public hospitals in South Africa are members of the IHF. The IHF aims to promote improvements in the planning and management of hospitals and primary health care services through international conferences, field study courses, training courses, information services, publications, research and development projects. (Khokar 1992:83.)

The General Assembly of the Federation normally meets every second year during the IHF congress. Members of the Congress elect the Council of Management, which has 21 members. The Council in turn elects from within its number an Executive Committee of four, which is responsible for conducting the affairs of the IHF between the Council's meetings. The IHF has its head office in Washington. It also has close contacts with other international health institutions in the health care field, and especially with the WHO, with which the IHF has an official link as a non-governmental organisation (NGO) (Khokar 1992:83).

The IHF performs a number of functions and render a number of services in order to improve primary health care services. These functions and services include the following.

(a) Publications

The Federation publishes an annual report on trends in primary health care, a journal on world hospitals and a quarterly newsletter. The journal, in particular, contains authoritative articles and reports on various aspects of international developments in the planning and functioning of hospitals

and primary health care services (Khokar 1992:83). IHF's publications provide health professionals from various countries including South Africa with the results of research in other countries. Furthermore, South African health professionals can submit the results of research undertaken locally on, for instance, primary health care for consideration and publication. It is therefore important for hospital managers in South Africa to read IHF's journals in order to improve the rendering of primary health care services.

(b) Congresses, conferences and seminars

The Federation further arranges international congresses, regional conferences and seminars at which representatives of all branches of, for instance, primary health care services can meet their colleagues from other countries and discuss common problems (Khokar 1992:83). The IHF conference held in Pakistan from 22-26 November 1991 recommended, among others, that the WHO and other national and non-professional institutions should maintain a continuing dialogue on the role of hospitals in primary health care (Khoker 1992: 83-84).

(c) Contact service

The IHF also maintains a contact service for its members on hospital and primary health care service matters anywhere in the world, and offers advice and assistance to members. There is also collaboration between the IHF member associations and other information centres as a means of providing an information service to members (Khokar 1992:84).

(d) Sponsoring of courses and involvement in projects

As Khokar (1992:84) states, a function that is closely related to contact service is the sponsoring of an annual 10 weeks course. This course is arranged jointly with the Health Services Management Centre of the University of Birmingham for senior hospital and health service managers from different countries. The aim of this course is to increase senior hospital and health service managers'

knowledge regarding the rendering of primary health care services (Khokar 1992:84).

Lastly, the IHF is also involved in projects and study groups on different aspects of hospital and health services. Such projects and study groups have included primary health care planning in urban areas, practices in mental health, health auxiliaries, hospitals and primary health care.

2.3.1.4 Commonwealth of Nations

The Commonwealth of Nations is an association of 199 independent states. The Commonwealth of Nations comprises mostly of countries that were once part of the British Empire and chose to remain in an organised association. Namibia and Mozambique were also allowed as members of the Commonwealth of Nations although they were former German and Portuguese colonies. The Commonwealth of Nations does not impose a common policy for health on its members (Padelford, Lincoln & Olvy 199: 486-7). Its members subscribe to the ideas of the Declaration of Commonwealth Principles that were unanimously approved by a meeting of heads of the Commonwealth governments in Singapore in 1971.

Ministers of health of the member states hold annual meetings, with major meetings every three years (Allan et al. 1997:100). The frequency of these meetings indicates the significance of the administration of health and in particular primary health care services for member states. These meetings are composed of policy-makers who can influence policies in their respective departments of health. Moreover, agreements regarding primary health care emanating from such meetings addresses problems experienced by South Africa such as the spread of HIV/AIDS.

Apart from the meetings held by the ministers, senior officials, cabinet secretaries, and permanent secretaries, heads of government meet regularly during the year between the annual meetings to provide continuity and to exchange views on various developments including the administration of primary health care services. Through these meetings, the Commonwealth of Nations secretariat facilitates the sharing of experience and the dissemination of research findings to member states in

order to maximise research impact on national policies (Harding 1999: 11May, E-mail).

Within its organisational structure, the Commonwealth of Nations has a Human Resource Division that consists of two departments concerned with education and health. The Health Department, in particular, arranges ministerial, technical and expert group meetings and workshops to promote co-operation on primary health care matters, and provides professional and technical advice to member states. (Allan et al. 1997:102.) Moreover, the Commonwealth of Nations Health Department, in collaboration with the Commonwealth of Nations Medical Association convened a training workshop on health policy in June 1997 in South Africa for Southern Africa. The purpose of this workshop was to align health policies including primary health care policies with the involvement of women. In addition, the Commonwealth of Nations Health Department publishes a journal titled Primary Health Care and Immunisation in Africa (Commonwealth 1999-online).

Although the Commonwealth of Nations is not an international health institution, it can influence policies on primary health care through agreements and declarations such as the Harare Commonwealth Nations Declaration of 1991. The foregoing Declaration, among others, aims to advance human development through health (Commonwealth 1999-online). In addition, deliberations and resolutions taken by Ministers' annual meetings may be taken into consideration during the drafting, debates, and approval of new legislation such as the New Health Bill in South Africa. Furthermore, the departments of health which fall within the area of study can ask for assistance from the Commonwealth since this institution is prepared to assist member states.

2.3.2 International-regional health and related institutions

Apart from the international institutions outlined above, the African continent has the African Union as its international-regional institution concerned with amongst others health matters. The functions of this institution regarding primary health care are explained below.

The African Union (AU) succeeded the Organisation of African Unity (OAU) which was formed

by African states on 25th May 1963. South Africa became the 53 member on 23 May 1994 (Department of Foreign Affairs 1998:7). The AU emerged out of the thirty-fifth Ordinary Session of the OAU in Algiers (Algeria) held on 12-14th July 1999 and the fourth extraordinary session of the OAU Assembly in Sirte in the Great Socialist People's Libyan Arab Jamahiriya held on 8-9th September 1999 which produced the Sirte Declaration (Sirte Declaration available at http://www.au2002.gov.za/docs/key_oau/sirte.htm).

According to the Constitutive Act of the AU (available at http://www.au2002.gov.za/docs/key_oau/au_act.htm) the AU consists of the following institutions:

- The Assembly of the AU which is composed of heads of African states and governments. The Assembly of the AU is the supreme authority on policy matters and it meets at least once a year;
- the Executive Council;
- the Pan African Parliament;
- the Court of Justice;
- the Commission;
- the Permanent Representative Committee;
- the specialised technical committees;
- the Economic, Social and Cultural Council; and
- the financial institutions (Leaders agree on AU available at http://news.bbc.co.uk/hi/english/world/africa/newsid_1198911.st)

Furthermore, article 13 of the Constitutive Act of the African Union makes provision for the Executive Council to co-ordinate and take decisions on policies in areas of common interest to the member states. Health is among the areas of common interest mentioned in article 13.

In addition to the policy-making functions of the Executive Council regarding health matters,

article 14 of the Constitutive Act of the African Union establishes, amongst others, the Committee of Health, Labour and Social Affairs. The Committee is mandated by article 15 of the Constitutive Act of the African Union to perform the following functions within its field of competence:

- prepare, amongst others, health projects and programmes of the AU and submit them to the Executive Council;
- ensure the supervision, follow-up and the evaluation of the implementation of decisions taken by the AU;
- ensure the co-ordination and harmonisation of health, labour and social affairs projects and programmes of the AU;
- submit to the Executive Council either on its initiative or at the request of the Executive Council, reports and recommendations on the implementation of the AU Constitutive Act; and
- carry out any functions assigned to it for the purpose of ensuring the implementation of the provisions of the AU Constitutive Act (African Union Constitutive Act available at http://www.au2002.gov.za/docs/key_oau/au_act.htm).

Mohammed (Challenges for the AU available at http://www.uneca.org.eca_resources...eches/030202presentation_abdul.htm) identifies HIV/AIDS pandemic as one of the challenges lying ahead of the AU. Furthermore, the AU, its institutions and member states have a key role in monitoring governments' performance, ensuring that best practices are followed and making sure that standards are continually upgraded. The monitoring of governments is important because the AU will be able to see if HIV/AIDS prevention strategies used by various governments are effective.

Furthermore, Mohammed emphasises the significant role of sub-regional institutions. Institutions such as SADC which serve the African needs best were not dismantled at the inception of the AU. However, another challenge for the AU is how to make sub-regional institutions such as SADC and their initiative work effective without duplications.

2.3.3 International sub-regional health institutions

While the AU focuses on the African continent, the SADC is concerned with the Southern part of Africa. Primary health care is amongst the responsibilities of the SADC in the sub-region.

The Southern African Development Community (SADC) was created by a treaty on 17 August 1992 and comprises of The Republic of Angola, Republic of Botswana, Kingdom of Lesotho, Republic of Malawi, Republic of Mauritius, Peoples' Republic of Mozambique, Republic of Namibia, South Africa, Kingdom of Swaziland, Republic of Tanzania, Republic of Zambia and the Republic of Zimbabwe. The SADC was created out of the former Southern African Development Co-ordinating Conference (SADCC). The SADCC existed for a period of 12 years but largely failed to make significant progress towards its main objective that was to reduce dependence of Southern African states on South Africa and to create a genuine and equitable regional integration. However, it could be said that the SADCC did succeed in the creation of a sense of regional identity although this has never been its main objective. This sense of regional identity became clear when the SADCC formed the SADC with its entire original members and later being joined by South Africa.

Immediately after its inception, the SADC committed itself to economic and political integration of the various member states by the year 2034. Other original objectives of the SADC were the harmonisation of the member states' macroeconomic policies; the creation of a free trade zone, the achievement of a customs union; the establishment of a full economic union with integrated monetary and fiscal systems and a regional parliament similar to the European Union. (Roelofse-Campbel 1997:28.)

Although the foregoing exposition gives an impression that the SADC was established to pursue economic objectives, this institution's role in the administration of primary health care services should not be underscored. The SADC adopted a sectoral approach to its functions. It has established committees and sector co-ordinating units to guide and co-ordinate regional policies

and programmes in specific areas such as health, which include primary health care. The sectors are allocated to individual states to co-ordinate and provide leadership. South Africa, for instance, assumes a leadership role in finance, investment and the health sector of SADC. This responsibility involves the attendance of meetings and workshops in the foregoing sectors by the concerned South African national line-function departments. Sectoral committees of ministers supervise sectoral activities. The minister representing the sector co-ordinating country chairs the sectoral committee (Department of Foreign Affairs 1997:4-5.)

The SADC as a regional institution closer to South Africa can influence the health policy and the allocation of financial resources used for the administration of primary health care services. The SADC can for instance, advise South Africa on policy and the allocation of resources for the rendering of primary health care services. In addition, the SADC co-ordinates technical aid for South Africa from its member states. Representatives of SADC member states at ministerial level meet at least twice a year. Furthermore, special meetings are held to co-ordinate regional policy in a particular field by, for example, ministers of health. (Allan et al. 1992:121.) In addition, the SADC helps to alleviate the region's shortage of skilled manpower by providing training for high-level managerial personnel. The training of such personnel has a positive impact on policy-making and solutions to problems in the administration of primary health care services. Skilled managers in South Africa can contribute positively in the administration of primary health care because they can conduct research on specific primary health care problems such as the prevention and spread of HIV/AIDS.

While the SADC or the AU's predecessors have somewhat been involved in the health sector activities in the past, both these institutions have many years of experience in the region and can continue to provide an authentic and indigenous approach to regional co-operation (Beattie, Rispel and Booysen 1993:934). These institutions are in a better position to influence primary health care policies in South Africa by virtue of their knowledge about problems in the African region. It is important for them to play an active role and collaborate with international health institutions such as the WHO.

2.4 RELATIONS BETWEEN SOUTH AFRICA AND INTERNATIONAL HEALTH INSTITUTIONS ON MATTERS PERTAINING TO PRIMARY HEALTH CARE

The relations between South Africa and international institutions are necessary for the co-ordination and integration of international, international regional and international sub-regional primary health care matters to increase efficiency and effectiveness. International relations can be defined as cross-border transactions of all kinds or the operation of none-state institutions (Brown 1997:3) such as the WHO. Within the context of this dissertation, international relations refer to the relationship between the South African National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health and Welfare, international, regional and sub-regional health institutions such as the WHO, AU and SADC.

Since the 1994 general elections, South Africa has become an active and strategically relevant member of the international health sector. Masobe and Seritsane (1998) mentioned that South Africa is a member of the WHO, Commonwealth and the IHF. Furthermore, the full admission of the country in the international sphere of health administration has a number of benefits for health care in general and primary health care services in particular.

Membership of international health institutions has advantages and disadvantages for an individual member state. In fact, the benefits (such as technical support and exchange of knowledge) that accrue to South Africa encouraged the country to become a member. Membership of these institutions involve certain rights and obligations or duties on member states, like in the case of South Africa, adapting existing legislation on primary health care and the payment of membership fees to these institutions. The South African National Department of Health issued a policy on the district health system in order to be in line with the WHO's guidelines. However, when weighed against the advantages such as membership, the obligations such membership fees that are imposed on South Africa and other countries by international health institutions are tolerable (Evans 1993:265).

For South Africa, there would be great value in having international experts, who operate under the aegis of institutions such as the WHO coming to the country to advise institutions involved in primary health care such as the National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health and Welfare in policy-making that will have an impact on the administration of primary health care services.

Other obligations for South Africa include the following:

- guidance in setting priorities for development assistance and utilisation;
- management to ensure the effective utilisation of, amongst others, primary health care resources, and
- an effective link between the South African health sector and the international health sector.(South Africa 1997a:191)

Furthermore, South Africa's relations in the field of health services continued to expand at an international level during 1995, a year highlighted by active participation of the health sector in international health development. The South African Minister of Health hosted the 11th Triennial Commonwealth Health Ministers meeting in Cape Town. In addition, various agencies, including the WHO, held their regional conferences and technical meetings in South Africa.

The number of meetings held in South Africa is an indication of a level of interest displayed by the international health institutions in the country. In most instances, the interest is coupled with a desire to provide financial assistance and advice. It is therefore advisable for the National Department of Health to utilise these opportunities to strengthen and improve the administration of primary health care services and advise the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare accordingly.

Technical assistance was negotiated by the South African government with various international

health institutions in support of the reform of the health system which was necessitated by the policy to move away from curative care (reactive approach) to primary health care (pro-active approach). Support has been received and has varied from consultative support to the funding of initiatives in such areas as primary health care and the training of nurse practitioners and health managers. For example, the WHO funded a number of projects, including a national capacity building programme. Furthermore, the WHO provided health resources such as finance for the improvement of health legislation. (South Africa 1995b: 71.) The improvement of, for instance, primary health care legislation required extensive consultation in and outside the country that involved costs such as printing of draft documents for distribution to the public and the contracting of experts.

The complexity of the activities of international health institutions prompted the National Department of Health to establish the Directorate: International Health Liaison within its organisational structure. The Directorate co-ordinates and manages all international health and donor activities. It is strategically positioned within the organisational structure of the National Department of Health to bring knowledge, skills and experience to bear on departmental policies. It also participates in all international relations-related activities of the National Department of Health. Moreover, it provides governmental decision-makers and the international community with up to date information on the administration of primary health care services in South Africa. (South Africa 1997a: 192-193.)

Information gathered by the Directorate: International Health Liaison can be used by the National Department of Health, the Gauteng Provincial Department of Health, the Emfuleni Department of Health to improve the rendering of primary health care services and to provide solutions to problems such as the spread of diseases which include, amongst others, HIV/AIDS. In addition, information gathered and provided by the Directorate: International Health Liaison can be helpful in governmental relations between the aforementioned three spheres of government in South Africa.

The relationship between South Africa and international health institutions is reciprocal. South Africa receives advises, financial assistance and publications with a bearing on primary health care and in turn make valuable inputs by participating in conferences. The South African Medical Research Council (SAMRC), for instance, has 400 full-time personnel; more researchers than the rest of the Southern African region combined (Beatie, Rispel & Booysen 1993:928). This implies that research conducted and co-ordinated by SAMRC on primary health care can benefit all countries that are members of SADC. The advises, financial assistance and research findings can be used for the improvement of primary health care services in the Emfuleni Department of Health and Welfare.

There is a need for the National Department of Health, the Gauteng Department of Health, and the Emfuleni Department of Health and Welfare to be informed about the current developments in the international sphere of primary health care and potential opportunities that may arise. The Directorate: International Health Liaison as an entry and exit point of information on international health is expected to play a pivotal role in the dissemination of vital information on primary health care. However, for this Directorate to succeed, it needs continuous improvement of the communication system and the commitment of the communication directorates in the aforementioned departments of health. The Gauteng Provincial Department of Health has installed an information system that costs R 1bn (Mazwai 1999:2) while the Emfuleni Department of Health and Welfare is expected to follow.

Lastly, the implementation of international health agreements related to primary health care such as the 1978 Alma Ata Declaration by the National Department of Health, the Gauteng Provincial Department of Health, and the Emfuleni Department of Health and Welfare has a bearing on international relations, which is the functional terrain of the Department of Foreign Affairs. Close co-ordination between the National Department of Health and the Department of Foreign Affairs on health and primary health care development in particular is crucial for a coherent approach to international health institutions. The Health Attach programme adds value to the work of the Department of Foreign Affairs in foreign health missions, but co-ordination of effort and

agreement on responsibilities is essential to avoid unnecessary duplication of functions (South Africa 1997a: 194).

2.5 SUMMARY

The preceding exposition revolves around the influence of international health institutions on the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. The characteristics of international health institutions are described hence their classification into international-universal institutions such as the WHO, international-regional institutions such as the AU and international sub-regional institutions such as SADC. The functions of each of these institutions were considered in the light of their impact on the administration of primary health care services in South Africa. The relationship between South Africa and the three categories of international health institutions regarding primary health care was also considered.

CHAPTER 3

NATIONAL PERSPECTIVE ON PRIMARY HEALTH CARE

3.1 INTRODUCTION

From the argument presented in the foregoing chapter it seems that international health and related institutions have a significant role to play in the rendering of primary health care services in South Africa. The historical development of the South African primary health care services has been characterised by the government's inability to recognise the importance of preventive health care until the Alma Ata Declaration in 1978. The cause of the inability to recognise primary health care can be attributed to the government-of-the-day as it has the authority to decide which approach has to be followed. This chapter describes the benefit-received and the ability-to-pay approaches to rendering primary health care in an attempt to explain how these two approaches apply in South Africa. Furthermore, the role of the National Department of Health in the influencing of legislation, financing and personnel within the context of primary health care is explained.

3.2 HISTORICAL DEVELOPMENT OF PRIMARY HEALTH CARE IN SOUTH AFRICA

To put the administration of primary health care further in perspective, it is necessary to outline the development of primary health care in South Africa. While many authors in the field of primary health care refer to the 1978 Alma Ata Declaration as an important international landmark in the development of primary health care, South African developments in this regard seem to date before the said declaration.

The health system in South Africa evolved from different origins, the two main contributors being Western medicine and the various African cultures with their traditional tribal medicine. This resulted in the development of two health care systems in this country, which have developed alongside each other, with western variation having official support. (Dennill, King, Lock &

Swanepoel 1995: 27.)

The health system was influenced during the colonial period by the British colonies such as Natal, Transvaal, Orange Free State and the Colony of the Cape of Good Hope prior to the unification of South Africa. The health care system that developed out of the political changes in government from colonisation to the unification of South Africa in 1910 was not well planned. After the unification of South Africa in 1910, fragmentation of health services occurred because of the legislation enacted that gave the four provinces control over their own health matters. (Dennill et al. 1995:29-30.) The power of provinces to control health and primary health care matters in particular was subjected to norms set by the national government.

The National Health Services Commission was appointed in 1942 under the chairmanship of Dr Gluckman (Gluckman Commission). In its investigation, the Gluckman Commission found that there was an inordinate emphasis on cure, curative services and institutional care, and not enough on either the prevention of diseases or community-based care. The Gluckman Commission criticised the lack of medical services necessary for the prevention of illnesses. Furthermore, it also found that services were not controlled on a national basis but that they are disjointed and haphazard, provincial and parochial; mainly directed not to health promotion and safeguarding of health, but to cure for illnesses; not equitably available to all sections of the community, especially the poor. (Van Rensburg, Fourie & Pretorius 1994:61.)

As a result of these findings, the Gluckman Commission recommended that health care be made available to all people and that there should be a preventive approach to health (Van Rensburg, Fourie & Pretorius 1994:61-62). Despite all the time and money used in the investigation, the government did not implement these recommendations because of its focus on curative health care which is contrary to the Commission's recommendations. The curative approach react to a disease that has developed while the primary health care approach advocated by the Gluckman Commission appears to be pro-active because diseases should be prevented before they start.

Sidney and Emily Kark are well known names in the history of primary health care in South Africa. Long before the advent of the Alma Ata Declaration, the Karks had developed a sophisticated holistic view of health problems based on a re-evaluation of traditional public health philosophy where epidemiological research and understanding of the social context of diseases were prime components. The Karks, both of whom were medical doctors, commenced their pioneering work into primary health care at Pholela Health Centre in Natal in the 1940s and 1950s. The Pholela health care experiment later ran into trouble as the government-of-the-day after 1948 placed increasing emphasis on curative care and high-tech medicine. The Karks faced increasing official opposition to their ideas of primary health care and eventually emigrated to Israel in 1948, whereupon the project collapsed. (Medlem 1993:3.) Primary health care in South Africa could have been more advanced if the government had agreed to follow both the curative and the preventive approaches as recommended by the Gluckman Commission and later implemented by the Karks.

After the emigration of the Karks in 1948, the government seems to have concentrated mainly on caring for the sick rather than the establishment of a solid foundation for the administration of primary health care. The failure of the government to take advices from the Karks and the Gluckman Commission was a major setback for the development of primary health care in South Africa.

The foregoing scenario is not, however, a surprise. Streefland and Chabot (1990: 13) point out that in the 1950's the government's concern focussed on the establishment of curative health systems in South Africa. It is for this reason that the Gluckman Commission's recommendations were not implemented. Hospitals were mainly established for members of the defence force and expatriates in urban settings due to the Second World War. The majority of people lived in scattered rural villages without access to curative institutions.

It was only in the 1960s, that a new dimension was added to primary health care when the UN called for a new 'economic order'. This moved the developmental focus from increased industrial

production to concern with peoples' basic needs including education and health care. It is the experience of the 1960s, with its profound idealism, its questioning of traditional values, and its courage to challenge old orders that laid the foundation for the new strategies for primary health care.

In 1978 the Alma Ata Declaration gave rise to a reawakening as regards to the government's approach to a primary health care policy. Even then, there were inequalities in the provision of these services. The roots for poor administration of health care services were laid in colonial times and have become entrenched in apartheid South Africa where one's race, class and place of residence were the major determinants in the health care that one received. This, compounded by socio-economic differences resulted in poorer health status for blacks and rural South Africans. (Buch 1989:34.)

Furthermore, Buch (1989:34) adds that previously only 12% of the health budget went to the former homelands where 40% of the population lived. The foregoing statistics prove that there was no equitable distribution of health care resources in South Africa. The allocation of financial resources in this way is indicative of the ideology of the then political party.

The 1986 final report of the Commission of Enquiry into Health Services further points out shortcomings which supports what Buch stated. The Commission highlighted the lack of central policy direction and the consequent miss-allocation of resources and wasteful duplication of services such as the rendering of primary health care services by clinics and hospitals. Moreover, the Commission points out with concern the under-emphasis on primary health care and an over-emphasis on expensive secondary and tertiary (curative) health services. (South Africa 1986:18.)

In 1994 South Africa celebrated its first democratic election and its move towards a democratic government. The next step facing South Africa since then has been to work towards achieving a better standard of living for all people including those who have long been deprived of decent health services. One such important aspect has been to avail to these people appropriate primary

health care services. This requires the identification of primary health care related problems and the formulation of a policy to address such problems. It is against this background that the provisions of the government's RDP which put more emphasis on primary health care was put into practice.

3.3 APPROACHES TO RENDERING PRIMARY HEALTH CARE AS A SOCIAL SERVICE

According to Nealer (1998: 5), service delivery by the authority of the state is brought about by the social "contract" about specific rights and duties that are in place between the government of the day and the country's inhabitants. The scarcity of resources makes it difficult for the health authorities for instance to satisfy all the needs. On the contrary, Nealer (1998:6) argues that especially developing countries such as South Africa are usually characterised by an unlimited number of community needs that have to be addressed with a limited number of resources and limited means.

Each political party plans its activities on the basis of a party political approach which is thought to be the best way of satisfying the needs of the citizens of the state such as the prevention of diseases- a goal of primary health care. In South Africa the ANC adopted the RDP which advocates primary health care. It is for this reason that ruling political parties in a democratic state such as South Africa have opponents. Opposition in the political sphere of public administration is a result of differences in, amongst others, whether primary health care policies should be implemented. Furthermore, the opposition ensures that the ruling party is always under fear of replacement after elections. This fear encourages the government to be more concerned about the accessibility of services such as primary health care.

Two approaches, that is, the benefit-received and ability-to-pay can be followed in the administration of primary health care services in South Africa. These approaches are described within the framework of public administration. The foregoing two approaches can affect the administration of primary health care in different ways such as committing less or more money to the rendering of primary health care services.

3.3.1 Benefit-received approach to primary health care

The benefit-received approach can be explained as a way of rendering primary health and other public services whereby members of the public pay the full costs of the services rendered. The government that follows the benefit-received approach can decide to levy charges for the rendering of primary health care services. According to Baily (1995:84) charges are used to cover costs, raise revenue and to meet the financial targets. In the application of the benefit-received approach, an attempt is made to determine the price of public services such as primary health care according to market forces.

The political party that advocates the benefit-received approach is likely to formulate primary health care policy that ensures that more private sector health institutions are created with a view to assist the authorities in the administration of primary health care services. Such a policy and the subsequent allocation of funds can have a negative impact on communities in developing countries such as South Africa. The majority of citizens in South Africa are poor and thirty percent are unemployed and thus cannot afford to pay more money for the improvement of their health status.

Van Rensburg, Fourie and Pretorious (1994:25) argue that the free-enterprise system, which is also a form of the benefit-received approach, is rare in health care. The health system of the United States of America seems to be one of the few health systems which leans strongly towards free enterprise, although it is not a pure prototype. In a free enterprise system, health care services are bought and sold like any commodity. The provision and distribution of services and facilities depends largely on the individual's purchasing power. Moreover, there is also minimal

intervention by the state regarding the supply, demand and price of health services and facilities. Private initiative in particular, play a decisive role in the provision of these services. (Van Rensburg, Fourie & Pretorious 1994:26.) For example, Prime Cure (a private health institution) renders primary health care services to people without medical insurance on a benefit-received approach. The South African public health services do not have the characteristics of the benefit-received approach although the establishment of private health facilities is encouraged.

3.3.2 "Ability-to-pay" approach to the rendering of primary health care services

The ability-to-pay approach requires government to render primary health care services to all members of the public including the poor and frail. The argument behind the ability-to-pay approach is that government services are not purchased like private sector services, and thus the market mechanism cannot decide the allocation of services, but a political decision will be a determining factor (Roos 1999:37).

With the development of a welfare economy by modernisation and industrialisation, a growing awareness developed of the needs of less privileged individuals in the community and the unequal position in which they found themselves regarding the more prosperous individuals. The justifiable needs of the poor prompted governments to try and create conditions within which such people could promote their own spiritual and physical welfare. The needs of the people had to be satisfied through the creation of social welfare security and the provision of social welfare services (Gildenhuys, Fox & Wissink 1991: 9.) such as primary health care by the government. Social welfare services include the rendering of free primary health care in South Africa.

The ability to pay approach has its roots in socialism. Van Rensburg, Fourie and Pretorious (1994:25) list the following characteristics that can be associated with the ability to pay approach.

- services are made available free of charge and health care is regarded as a right to all,

- most health personnel are employed as public servants,
- most health facilities are owned by government, and
- most institutions offer preventive and curative services.

The ability-to-pay approach means that the government guarantees good minimum living conditions to citizens by ensuring that there is equal access to primary health care and other services. The government owns some hospitals while the establishment of private health institutions is also encouraged. Preventive and curative services are rendered by separate institutions such as clinics and hospitals respectively (Van Rensburg, Fourie & Pretorious 1994:26).

In the case of the ability-to-pay approach, the government is regarded as a dynamic promoter of social reform and a distributor of social services to the individual and groups in the community as a whole. (Gildenhuys 1993:10.) This implies that the government has a positive role to lead the community into a better quality of life through the rendering of primary health care and other medical services.

Since the ability-to-pay approach welcomes the existence of private institutions, non-governmental and other private institutions interested in the improvement of primary health care services will also play a significant role. In this way, the demand for services rendered by the government will be minimised and the government will be able to concentrate and channel its scarce resources to improve the quality of services including primary health care for the poor who cannot afford services rendered by private health institutions.

The author's analysis of political developments in South Africa in relation to health services in general shows that, as regards the policy on health and primary health care services in particular, the government is in favour of the ability-to-pay approach. Its support for this approach manifests itself in the introduction of free primary health care services for pregnant women and children under the age of six years in public clinics and hospitals (Masobe & Seritsane 1998). Furthermore, the Minister of Finance stated in his budget speech of 1997-1998 that 500 new clinics have been

built by the government thereby bringing primary health care services closer to 5 million people. Free primary health care services to all benefits 32 million people who do not have medical aid in South Africa. (South Africa 1998a: 28.) In addition, the government allows and regulates the establishment of private medical facilities for people who can afford them.

Universal access to free primary health care services as a significant change in policy announced by the Minister of Health in April 1996, has some implications on the administration of primary health care services (South Africa 1997a: 17-18). It allows poor people who could not otherwise benefit from the services rendered by health institutions because of poverty, to avail themselves of such services. Moreover, whenever the number of clients for primary health care services increases, the volume of administrative work also increases accordingly. This implies that the amount of money budgeted for administration of primary health care services needs to be adjusted accordingly.

3.4 NATIONAL DEPARTMENT OF HEALTH

Public health institutions have a hierarchical structure with three spheres of government. Diagram 3 shows that, although the National Department of Health in South Africa is the highest authority on health in South Africa, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare are regarded as equal partners in the provision of primary health care services. The arrows inside the diagram signify intergovernmental relations which is discussed in detail in chapter six of this dissertation. Each of the spheres indicated in diagram 3 has different roles to play in the administration of primary health care. For instance, the National Department of Health provides support to the Gauteng Provincial Department of Health and the latter to the Emfuleni Department of Health and Welfare.

Furthermore, diagram 4 outlines the organisational structure of the National Department of Health. The Department is divided into ten chief directorates, each with directorates responsible for specific functions. Although there is no specific directorate responsible for primary health care

services, Directorates such as Health Promotion contribute to primary health care.

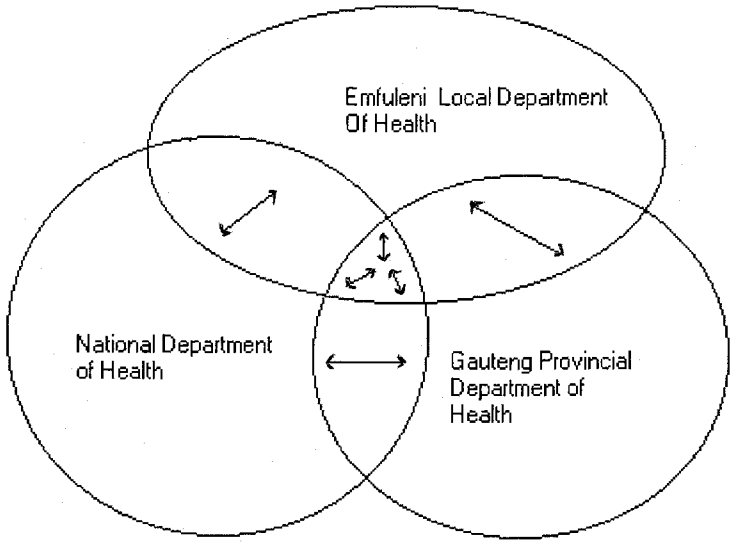
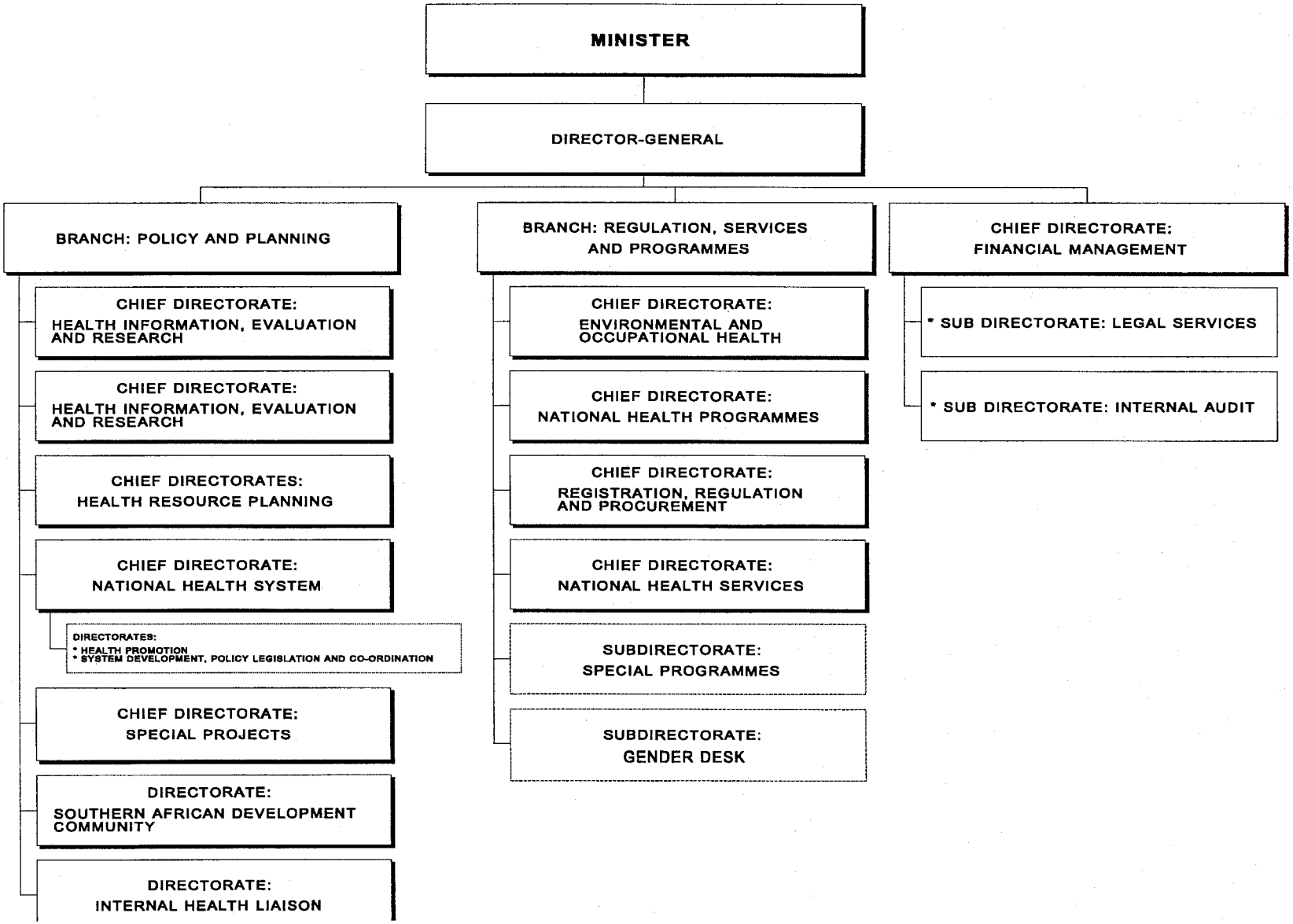


Diagram 3: Relations between national, provincial and local departments of health for primary health care

Source: Department of Constitutional Development (1998:11)

Diagram 4: Organogram -Department of Health



The National Department of Health has the responsibility for setting broad policy guidelines for all provincial and local departments of health in South Africa. The National Department of Health further co-ordinates and distributes national resources such as finance. The National Department of Health is also responsible for comparative monitoring of the performance of regions, districts and international co-operation as outlined in the previous chapter. These functions ensure that resources earmarked for the administration of primary health care services are distributed in an equitable manner to all provinces, and that each province has plans that take into account policies made by international institutions such as the WHO and the national government in South Africa.

The preamble of the *Constitution of the Republic of South Africa Act*, 1996 points to the importance of the improvement of the quality of life of all citizens. Section 27(1)(a) of the same legislation provides that everyone has the right to have access to health care services. The foregoing sections of the *Constitution of the Republic of South Africa Act*, 1996 mandates all departments of health under the guidance of the National Department of Health to render primary health care services. According to the 1995 Annual report of the National Department of Health (1995b: 30) other functions of this Department are:

- formulation of norms and standards for the administration of primary health care services,
- building effective human resource capacity in health departments,
- ensuring appropriate utilisation of resources such as human and finances which are necessary for the rendering of primary health care services,
- delivering national services which cannot be delivered cost effectively at the two lower spheres of government,
- co-ordinating information systems and monitoring national health goals on health and primary health care services in particular,
- regulating the public and private health care sectors in matters such as the delivery of primary health care services,
- ensuring access to cost-effective and appropriate health commodities at all spheres of government, and

- Liasing with health departments in other countries and international health agencies. (South Africa 1995b: 30.)

Parliament and the National Department of Health must ensure that they do not stifle provincial and local authorities. This appears to be possible given the broad planning role of the National Department of Health. Regional and local initiatives may be successful using approaches different from those that are imposed at the national sphere. According to Zwarenstein and Baron (1992:4) the monitoring role needs to be developed to a high level if it is to be used to provide comparative information, without the temptation to excessive centralisation of power.

In addition to the Head Office of the National Department of Health, there are a number of regional offices throughout the country. The regional offices of the National Department of Health can strengthen governmental relations between the three spheres of government as regards primary health care. The role of these offices is to enable the districts to carry out their functions, to provide support in the form of supplies and personnel functions such as merit rating, appointments and training. The regional offices of the National Department of Health can also be the spheres at which inter-sectoral planning between for instance the National Department of Health and the National Department of Education takes place, and where intra-sectoral discussions between the three spheres of health authorities take place and plans affecting more than one district are resolved. The regions have a third function, namely to assist in the event of failures on the part of the districts. The support role played by the regional offices of the National Department of Health is likely to be reduced as districts develop further as regards to knowledge. The regional health office may initially have to offer support in the form of detailed guidelines beyond what is ideal in terms of levels of autonomy. (Zwarenstein & Baron 1992:4.)

3.4.1 Influence of legislation on primary health care on the national sphere of government

For administrative executive institutions such as the National Department of Health to function properly, they need a policy based on real community needs which serves as a guide. In terms of

section 43 of the *Constitution of the Republic of South Africa Act*, 1996 the legislative authority at national sphere is vested in Parliament, which consists of the National Assembly and the National Council of Provinces. In addition, section 44 of the *Constitution of the Republic of South Africa Act*, 1996 allows Parliament to make laws which direct the activities of the administrative executive institutions such as the National Department of Health in general and primary health care services in particular for all three spheres of government. The RDP as a government policy guideline for instance, states that the National Health System must be driven by the primary health care approach (African National Congress 1994:24).

The changes that were made in the sphere of primary health care since the 1994 general elections are a testimony of the strength of the national government as regards to making policy changes. Whenever a political party wins an election, changes in policy become inevitable in particular regarding the rendering of primary health care services. In 1994 for instance, the new South African Government introduced free primary health care to children under the age of six and pregnant women. It therefore stands to reason that although the current policy on the rendering of primary health care services is in line with the requirements of the Alma Ata Declaration, there is no guarantee that it will be retained for the next decade because another strong political party may emerge with its own new approach to primary health care.

Schedule 4, part A of the *Constitution of the Republic of South Africa Act*, 1996 classify health services as an area of concurrent national and provincial legislative competence. This implies that both the national and provincial legislatures including Gauteng Province can make laws pertaining to primary health care services. The *Health Act*, 1977 is an example of legislation made at national sphere. The Gauteng Province cannot pass legislation on health that is contrary to the contents the *Health Act*, 1977 and other legislation made by the national legislature.

In terms of section 1 of the *Constitution of the Republic of South Africa Act, 1996* South Africa is a unitary state. This implies that the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare should also implement the policy on primary health care

services approved by the national legislature. The Emfuleni Local Authority, for instance, is divided into two health districts. This is an attempt to give effect to the national policy on the implementation of the district health system.

3.4.2 Financing of primary health care services

State departments cannot render services if funds have not been made available by Parliament. The allocation of funds for primary health care and other services can only take place after Parliament has established sources of revenue. It is for this reason that section 213(1) of the *Constitution of the Republic of South Africa Act,* 1996 states that there is a National Revenue Fund (Fund) into which all money received by the national government from taxation must be deposited. Money deposited into this Fund may only be withdrawn in terms of an act of Parliament for the rendering of services in general and in particular primary health care. The Department of State Expenditure keeps the National Revenue Account. For this Fund the Account of the Exchequer of the Republic of South Africa is kept by the South African Reserve Bank which serve as the bank for the central government. (Cloete 1993:35.)

In his budget speech of 1997/98 the Minister of Finance indicated that the main increase in health spending occurred in 1996/97 when spending increased by 24 percent, from R17 billion to R21 billion. The national budget provides for expenditure of R201 billion for 1998/9 that is 6.4 percent above the revised 1997/8 expenditure level. Health services in general received R23 billion from the national budget. (South Africa 1998a: 13.) Furthermore, the National Expenditure Survey for the year 2000 indicated that in addition to the 2000/01 national health budget, a special HIV/AIDS allocation has been approved. The allocation will comprise R75 million in 2000/01, increasing to R125 million in 2001/02 and to R250 million in 2002/03 (South Africa 2000a: 114). The channelling of more funds to HIV/AIDS is an indication of the government's priority as regards preventive health care.

Before Parliament can authorise expenditure for a specific financial year (which is normally from

1 April to 31 March of the ensuing year), the National Department of Health, amongst others, must make projections of the funds needed for its programmes (Cloete 1998: 199). This implies that the National Department of Health as an administrative executive institution of the government regarding health care in general and primary health care in particular has to make projections in view of the needs of the public and limited resources.

The National Department of Finance plays an important role in this regard by issuing guidelines to be used in the preparation of the budget. After the preparation of a consolidated departmental budget, which include funds for the administration of primary health care services, the departmental budget is submitted to the National Department of Finance. After consolidation of all budget votes by the National Department of Finance, the Cabinet considers the budget document. Eventually, the budget document will be presented in Parliament for approval where after the National Department of Finance will be authorised to spend the appropriated funds.

The procedure outlined above and the provision of section 213(2)(a) of the *Constitution of the Republic of South Africa Act*, 1996 shows that Parliament has the final say on the financing of government spending in general and primary health care services in particular. It is for this reason that the Minister of Health in particular has to account to Parliament and the latter accounts to the voters for the use of public funds appropriated for amongst others primary health care and other services.

3.4.3 Personnel of the National Department of Health

The size or number of personnel employed by the National Department of Health has a bearing on its ability to render qualitative primary health care services. Prior to 1994 South Africa was divided into four provinces, four independent states and six self-governing territories (Cloete 1993:21). Each of these entities had its own department of health with a number of personnel. Subsequently, in 1994 all these health departments had to be unified. During the restructuring of these departments it became clear that national and provincial departments had more personnel than

they needed for the administration and rendering of primary health care services.

As a result of the foregoing circumstances, which were not peculiar to the National Department of Health, the Cabinet directed in October 1995 that the number of personnel in the public service be reduced. Subsequent to the decision by Cabinet, the Department of Public Service and Administration issued circular 10/12/26 on 26 May 1996. The circular serves as a guide for the reduction of personnel in the public service as a whole and in particular the National Department of Health and the Gauteng Provincial Department of Health and the implementation of voluntary severance packages.

The reduction of personnel of the National Department of Health is important since the salaries of government officials constitute a sizeable percentage of the total expenditure on health matters. It is therefore important to discharge redundant officials because they contribute to the expenditure while they do not contribute to the improved delivery of services such as health and in particular primary health care.

The decision by the Cabinet to offer severance packages to serving officials was implemented by the National Department of Health with effect from 1 August 1996. The implementation of this decision decreased the number of employees of the National Department Health and primary health care offices towards the end of the same year. In total, 192 posts were abolished in the National Department of Health and thereby saving R9, 8 million which could in turn be used to improve primary health care services. Furthermore, 164 applications for severance package were received of which 25 were not approved because some of the officials had skills and knowledge that the National Department of Health needed to fulfil critical functions such as policy-making and research. The savings achieved by the initiative amount to R2, 3 million for the 1996/97 financial year. (South Africa 1996b: 12.)

The saving resulting from the offering of severance packages to personnel of the National Department of Health who wished to be laid-off assisted the Department in human resource

development and capacity building required for the rendering of primary health care services. According to the 1998/9 Annual Report of the National Department of Health (1999a: 35), the focus of capacity building in the health sector has been on the orientation towards primary health care and management training. In 1998, 3686 nurses were trained in primary health care and 2435 health personnel were trained in management skills.

3.5 SUMMARY

The success of the National Department of Health in the implementation of primary health care policies depends on the ability to identify historical inequalities and problems that can be traced back to the previous health systems. Although Parliament decides whether to follow the benefit-received or the ability-to-pay approach, the National Department of Health, with its broad policy-making powers which are subject to the *Constitution of the Republic of South Africa Act*, 1996 is expected to play a significant role in the rendering of primary health care services. Legislation, finance and personnel are amongst the important functions that cannot be ignored in the rendering of primary health care services.

CHAPTER 4

PRIMARY HEALTH CARE SERVICE WITH SPECIFIC REFERENCE TO GAUTENG PROVINCIAL DEPARTMENT OF HEALTH

4.1 INTRODUCTION

In this chapter a description will be given of the role and functions of the Gauteng Provincial Department of Health in relation to the National Department of Health as described in the previous chapter and the Emfuleni Department of Health and Welfare regarding primary health care services. The rendering of primary health care services in the Gauteng Province is characterised by inequitable and duplication of services, for an example, the rendering of the same service such as primary health care by the province and local authorities in the same area. In an attempt to solve this problem, the Gauteng Provincial Department of Health is currently implementing the district health system. Furthermore, health promotion receives attention in this chapter as a means of solving the problem regarding the spread of diseases such as HIV/AIDS. In addition, corruption and theft are also described as the two phenomena that can undermine any positive development in the area of primary health care. Finally the role of non-governmental organisations and other private sector institutions is described with a view to analyse their contribution to primary health care.

4.2 ROLE AND FUNCTION OF GAUTENG PROVINCIAL DEPARTMENT OF HEALTH IN THE ADMINISTRATION OF PRIMARY HEALTH CARE IN GAUTENG

The Gauteng Provincial Department of Health is one of the nine provincial departments of health co-operating with the National Department of Health in the implementation of primary health care services in South Africa. The Gauteng Provincial Department of Health renders primary and other health care services in collaboration with the private health institutions and local authorities such as the Emfuleni Local Authority to people within the Gauteng Province.

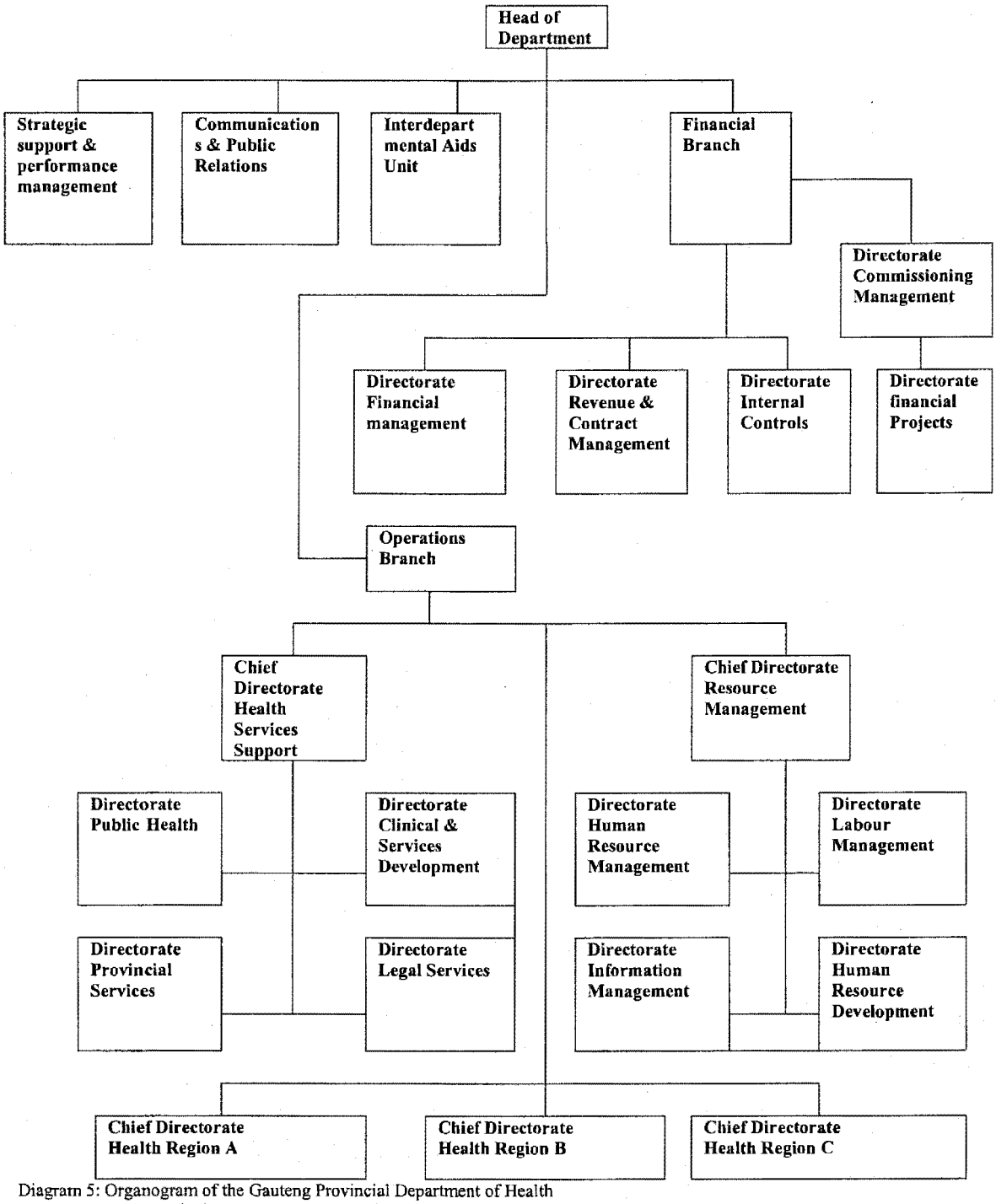


Diagram 5: Organogram of the Gauteng Provincial Department of Health
Source: Gauteng Provincial Department of Health: Email attachment

Diagram 5 on page 63 shows that, amongst others, the Gauteng Provincial Department of Health is composed of two branches, namely the Financial Branch and Operations Branch. The Operations Branch appears to be relevant to primary health care as it is responsible for health services support. In addition, three chief directorates within the Operations Branch are established to cater for metropolitan area services, district services and systems support. Apart from the aforementioned main branches, the Gauteng Provincial Department of Health has an interdepartmental Aids Unit. The Interdepartmental Aids Unit co-ordinates HIV/AIDS related activities undertaken by all Gauteng Provincial departments.

According to the South Africa Yearbook (1999b: 13) the Gauteng Province is highly urbanised and the most densely populated province in South Africa. Geographically, the Gauteng Province is the smallest province (17010 km^2) but houses 7,35 million people, which is 18% of the total population of South Africa. Furthermore, the rate of urbanisation is 97 percent (South Africa Yearbook 1999b: 13) This implies that the Gauteng Provincial Department of Health and Emfuleni Department of Health and Welfare have to render primary health care services to a dense population within its limited resources.

In terms of Schedule 4(a) of the *Constitution of the Republic of South Africa Act, 1996* as previously stated, health services are functional areas of concurrent national and provincial legislative competence. This implies that the Gauteng and other provincial legislatures can make laws on matters such as amongst others primary health care. The Gauteng Provincial Department of Health then implements these laws. The *Gauteng District Health Services Act, 2000 (Act 8 of 2000)* is an example of such legislation. The *Gauteng District Health Services Act, 2000* guides the Gauteng Provincial Department of Health on the establishment of health districts for municipalities such as Emfuleni. This Act should not contradict with policies on the national sphere such as the *Policy for the Development of a District Health System in South Africa (South Africa 1995a)*. Should there be a conflict of laws, section 146 of the *Constitution of the Republic of South Africa Act, 1996* provides that the national legislation and policies supersedes the laws made by a provincial legislature.

The functions of the Gauteng Provincial Department of Health as regards primary and other health matters as prescribed by the *Gauteng District Health Services Act, 2000* are as follows:

- the formulation and implementation of provincial health policies, norms, standards and legislation on a variety of health matters including primary health care in consultation with the Department of Development Planning and local authorities such as Emfuleni;
- ensure equity in health care service provision within the Gauteng Province;
- support local authorities (such as the Emfuleni Local authority) in order to ensure that primary health care services is delivered;
- ensure the planning and implementation of a Gauteng Provincial health information system;
- develop funding criteria, co-ordination and monitoring mechanisms and financial monitoring systems for primary health care services (provided by the Emfuleni Local Authority);
- identify populations that are vulnerable to infectious diseases and address their special needs in conjunction with local authorities.

In addition to the functions outlined above, the Regional Health Office established by the Gauteng Provincial Department of Health in the Vaal Triangle has a significant role to play in the rendering of primary health care services. According to Soloojee (2000) the Vaal Regional Health Office is responsible for the following:

- administration/management of primary health care facilities which are the responsibility of the province in the Vaal Health Region;
- administration/management and control of expenditure in primary health care facilities;
- co-ordination and implementation of primary and other health care programmes;
- training and capacitating personnel such as nurses employed by the Emfuleni Department of Health and Welfare in primary health care; and
- promoting marketing research and communication on, for example, primary health care activities such as child immunisation for polio in the Emfuleni area.

Furthermore, the Gauteng Provincial Department of Health is empowered by section 139 of the *Constitution the Republic of South Africa Act, 1996* to supervise local departments of health including the Emfuleni Department of Health and Welfare. If the Emfuleni Department of Health and Welfare cannot fulfil some of the executive functions regarding primary health care and the Gauteng Provincial Department of Health does not play its supervisory role to correct the situation, the National Department of Health can intervene to ensure that the obligation is fulfilled. This is a measure to ensure that essential services such as primary health care are not disrupted. In addition, a policy measure, which brings services closer to members of the public, is the district health system.

4.3 IMPLEMENTATION OF THE DISTRICT HEALTH SYSTEM BY THE GAUTENG PROVINCIAL DEPARTMENT OF HEALTH

The district health system has been introduced in South Africa because the national and provincial governments are too far removed from the community to be responsive to local needs. It is the responsibility of the Gauteng Provincial Department of Health to ensure that the district health system is implemented in accordance with the *National Policy for the Development of the District Health System* and the *Gauteng District Health Services Act, 2000.* The argument for the implementation of the district health system is that primary health care functions can be more effectively managed by decentralising them to smaller geographic and administrative areas called districts such as the Emfuleni health districts. These areas can also be local spheres of government (South Africa 1995a: 6) such as the area of jurisdiction of the Emfuleni Local Authority.

The health district, because of its size and closeness to the people it serves, has the potential to allow for structured and meaningful community participation in policy-making and evaluation. Where possible, it should coincide with similar areas of service delivery of other sectors such as education in order to enhance inter-sectoral collaboration (South Africa 1995a: 7) such as health promotion at schools.

The WHO as quoted in a *Policy for the Development of a District Health System in South Africa* (1995a: 6), describes a district health system as the delivery of health services which is based on primary health care. Furthermore, the district health system is seen as a more or less self-contained segment of the national health system within a province such as Gauteng. This health system consists of a well-defined population, living within a demarcated geographical area that may be a rural or an urban area such as the Emfuleni Local Authority. The district health system includes governmental, social security, non-governmental, private and traditional institutions and individual health care providers. This system of health provision has inter-related structures which contribute to health in homes, schools, work places and communities through the health and the related non-health sectors. The district health system emphasises self-care as well as the involvement of all health workers and facilities.

The boundaries of the health district should not cross the boundaries of other boundaries such as local authorities and magisterial districts. Health districts do not need to be permanent and should be subject to change over time to improve the management of the district, especially when local authorities boundaries change or as health management capacity increases and a large district can be divided into smaller health districts. (South Africa 1995a: 7.) The Emfuleni Local Authority for instance, has two districts. (Saloojee 2000).

Furthermore, Saloojee (2000) points out two main problems in the development of the district health system in the Vaal Triangle. Firstly, the process of decentralising personnel within districts is not complete, as some personnel do not co-operate due to fear and uncertainty. Although personnel have the right to choose, their rights should be subordinate to the needs that exist for redeployment. This suggests that disciplinary actions can be taken against such personnel. Secondly, district health management is still problematic in the Vaal Triagle including the Emuleni Department of Health and Welfare, as the concept of district health is still new in South Africa. The concept district health management was used in primary health care since 1994.

The decentralisation of personnel needs urgent attention as most health facilities in the Emfuleni

Local Authority's two health districts do not have sufficient personnel and this means that the policy on the development of the district health system will be meaningless if there are no personnel to implement it. The transfer of personnel from the Gauteng Provincial Department of Health and to the Emfuleni Department of Health and Welfare should be dealt with in terms of the *Transfer of Staff to Municipalities Act, 1998 (Act 17 of 1998)*. The *Transfer of Staff to Municipalities Act, 1998* allows health and other departments such as the Gauteng Provincial Department of Health to transfer personnel for instance to the Emfuleni Department of Health and Welfare without changes in the conditions of service. Closely related to the transfer of personnel to municipalities is the need to have sound management at the local sphere of government such as Emfuleni Local Authority.

The administration of the district health system requires the Emfuleni Department of Health and Welfare in conjunction with the Gauteng Provincial Department of Health to arrange workshops and training courses on the management of primary health care and the district health system in particular. Such workshops and training courses will improve managerial skills such as personnel and financial management of district health managers. The administration of primary health care services is important for the success of primary health care programmes in the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare.

In addition to the above, the internal efficiency of the systems of primary health care service provision is important as internal efficiency determine how objectives are to be attained. Schwella (1992:13) for instance, envisages the population of South Africa to increase from 33,2 million in 1985 to 47,2 million by year 2000 and to 70,8 million by 2020. These figures suggest a doubling of the population within a period of 25 years. The increase of South African population suggests that the population of the Gauteng Province and the Emfuleni Local Authority in particular will also increase in proportion to the national figures. The rapid increase of the population requires the management/administration of primary health care services by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare to be cost effective. A strategy that can minimise costs by preventing diseases leads to health promotion that is described in section 4.4.

For purposes of implementing the district health system in the Gauteng Province, the following institutions have been established.

4.3.1 District health authority

In terms of section 9(1) of the *Gauteng District Health Service Act*, 2000 a district health authority is established by the Member of the Executive Committee for Health in consultation with the relevant local authorities such as Emfuleni and the Member of the Executive Committee for Local Government. A district health authority is a governing body responsible for policy decisions over matters that affect the local community on important issues such as policy and finance. In the performance of its duties, the district health authority must consult the community of, for instance, Emfuleni. The Provincial Member of the Executive Committee responsible for health in the Gauteng Province and the Gauteng Department of Health are responsible for monitoring service delivery to communities. The Gauteng Province has five regions one of which is the Vaal and 25 health districts which include Emfuleni (National Department of Health 1998b: 6-7).

4.3.2 District health management team

The district health management team consists of a district manager, support personnel in functional areas such as finance and personnel, a primary health care co-ordinator and a health information officer. The District Health Management Team of the Emfuleni Local Authority, for instance, is accountable to the District Health Authority through the district health manager (National Department of Health 1998b: 6).

Furthermore, the district health management team of Emfuleni is by implication responsible for the following:

- providing leadership and managing the health affairs of the district such;

- supervising and providing technical support;
- capacity building such as the training of personnel;
- facilitation of community participation and involvement;
- ensuring collaboration between various government departments such as education and health; and
- monitoring and continuously striving to improve the health status of the community (National Department of Health 1998b: 6).

The effective functioning of the district health authority and the district health management team will expedite the implementation of the district health system in the Gauteng Province. The success of the district health system relies on health promotion that is described hereunder.

4.4 HEALTH PROMOTION

A Canadian Minister of Health and Welfare first used the term health promotion in 1974. He argued that the major causes of death and diseases lay not in biomedical characteristics but in the environment, individual behaviours and lifestyles. (Wills & Naidoo 1994:74.) According to the WHO's Charter signed in Ottawa in 1996, health promotion is the process of enabling people to increase control over, and to improve their health (Commonwealth-Online: 2000). Health promotion as a strategy for the prevention of diseases was subsequently supported by the WHO at the Alma-Ata conference in 1978 and adopted by countries such as South Africa.

According to the National Department of Health Annual Report (South Africa 2000b: 22) the primary purpose of health promotion is to enhance the management/administration of environmental determinants which impact on the quality of health. The major thrust of health promotion effort is the development of collaboration between provincial departments of health, other government departments such as education and sectors outside government such as non-governmental organisations and businesses.

In South Africa the *White Paper for the Transformation of the Health System,* 1997 envisages structures at national, provincial, and district levels to facilitate the planning, implementation, co-ordination, monitoring and evaluation of health promotion and communication activities. At the national level, the Health Promotion and Communication Directorate was established while in Gauteng and other provinces there are health promotion teams. Each district including the Emfuleni Local Authority's districts have an officer responsible for health promotion (such as the involvement of schools in health promotion) within the district. (South Africa 1997b: 180-181.)

In addition, Saloojee (2000) states that there is a health promotion directorate at the Vaal Triangle Office of the Provincial Department of Health. The health promotion directorate seeks to promote healthy lifestyles within the community and help the people in the Vaal Triangle to reach optimum levels of health through self-upliftment and self-reliance. The mission of the directorate is to develop personal skills, reshape the health service and ensure that there are healthy environments. Furthermore, the directorate envisages that people will take responsibility for their own health and thereby reduce the number of people using hospital facilities. If the goals of the health promotion directorate in the Vaal Triangle are realised, most health problems will only need to be treated at primary health level unless a referral is inevitable.

According to Wills and Naidoo (1994:75), the WHO bases health promotion on the following **five key principles:**

- the **involvement of the population** as a whole in the context of their everyday life, rather than focussing on people at risk from diseases such as HIV/AIDS (in the Gauteng Province and the Emfuleni local area in particular),
- it is directed towards **action on the causes or determinants of health hazards** to ensure that the total environment which is beyond the control of individuals is conducive to health,
- it **combines diverse and complementary methods** which include communication, education, legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards such as the actions taken by NGO's to

inform the community about HIV/AIDS prevention,

- it aims particularly at **effective community participation supporting the principle of self-help** and encouraging people (for instance, in Emfuleni) to find their own ways of managing the health of the community. Effective community participation is lacking in the Emfuleni local area and it therefore requires the attention of politicians and officials.
- while health promotion is basically an activity in the health and social fields and not a medical service, health professionals (particularly in the primary health care sector in the Emfuleni Local Authority) have an important role to play in nurturing and enabling health promotion.

Furthermore, effective communication underpins every health promotion activity. However, in the Emfuleni Local Authority's area of jurisdiction, communication between the local community and the Emfuleni Department of Health and Welfare is impaired. Communication must be participatory, gender sensitive and two-way. Innovative and culturally acceptable methods of communication needs to be utilised by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. Section 6(1) and (5) of the *Constitution of Republic of South Africa Act, 1996* recognises the eleven official languages and sign language. It is therefore the duty of Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare to ensure all languages spoken in the Emfuleni area of jurisdiction are used to improve communication. In addition, special communication should be developed for the disabled and illiterate people. (South Africa 1997a: 183.) Sign language and Braille are examples of special languages that should be used by the Gauteng and the Emfuleni departments of health in health promotion.

In addition to efforts to improve communication, primary health care in the Emfuleni Department of Health and Welfare provides an environment where health promotion at primary, secondary and tertiary levels takes place. An example of primary promotion is preventing the occurrence of ill health through the provision of child immunisation services against diseases such as polio. Secondary promotion is preventing ill health becoming chronic and restoring affected people in the Emfuleni area to their previous level of health. An example of secondary prevention is advising

someone with bronchitis to give up smoking. Tertiary prevention focuses on helping people with chronic or irreversible ill health how to cope with their conditions and enjoy their maximum potential for health. This is illustrated by the example of asthma clinics which teach people to monitor and manage their own conditions. (Naidoo & Wills 1994: 259-260.)

Furthermore, primary health care is a key approach for health promotion in, for example, the Gauteng Province and the Emfuleni Local Authority because most people have contact with primary health care practitioners (Naidoo & Wills 1994:260.) Nurses carry out much of the health promotion practised in primary health care settings. This view is supported by Saloojee (2000) as she also argues that 72% of the population in the Vaal Triangle require primary health care services.

In an attempt to assist provinces such as Gauteng and the local authorities, the National Department of Health concentrated on three areas of health promotion in 1998. These areas were the development of health promoting schools network, the establishment of health promotion forums and the contribution in the drafting of the Tobacco Products Amendment Act, 1999 (Act 12 of 1999). Health departments in provinces such as Gauteng have subsequently linked up with provincial departments of education in an attempt to educate people about their health. To advance the health promotion idea further, a draft policy on health promotion was discussed at a provincial workshop held in November 1998. In addition, the Health Promotion Forum was launched on 20 August 1998. The aim of this forum is to develop health promotion practices. The forum's committee is comprised of representatives of the National Department of Health, NGO's and the Medical Research Council. (South Africa 1999a: 50.)

Primary health care, which is at the centre of health promotion, emphasises prevention rather than cure. The success of primary health care programmes depends on the extent to which the community knows about and adheres to ways to prevent diseases such as HIV/AIDS and tuberculosis from spreading. Knowledge regarding prevention of diseases can be spread through education. However, health facilities such as clinics in the Emfuleni area do not have the human

and financial resources to undertake educational programmes.

Despite the limitation of resources mentioned above, hospitals and clinics remain the best places to provide health education to patients, their families, relatives and friends. Since the latter are all the more concerned, they can listen and are far more receptive to anything related to health than people having no current involvement with the hospitals and clinics. Hospitals and clinics in the Emfuleni Department of Health and Welfare represent just the initial steps of a chain process wherein patients, their families and friends become the agents of health education in the community. In this context, health teaching of non-professional hospital personnel such as cleaners becomes an obligation. This type of arrangement can be very useful since many patients will discuss their illnesses more freely with lay persons and more easily share with them their concerns. (Khokar 1992:12.)

In addition to the use of word of mouth in educating the community, a number of techniques may be used. Khokar (1992:12) is in favour of the use of leaflets, pamphlets, flipcharts, posters, large banners, health exhibits, videotapes, and public address systems to give health messages such as HIV/AIDS prevention to patients. Furthermore, health education stalls, films and closed circuit television may be used in outpatient departments, in patients wards, dispensing areas and other waiting areas. The foregoing techniques may be educational and lead to better time management, as patients are idle for some time while waiting for consultations with nurses and doctors. The Emfuleni Department of Health and Welfare does not use most of the foregoing health promotion techniques due to lack of funds.

Apart from the foregoing health promotion techniques, radio and television programmes on the prevention of various diseases can also be designed for the public at large. In this regard the Emfuleni Department of Health and Welfare, the Gauteng Provincial Department of Health in collaboration with the National Department of Health have to target a specific time when viewers and listeners are at home. For example, it is common knowledge that most South Africans are at home at eight o'clock in the evening. This is therefore the ideal time to use radio stations such as

Lesedi, Metro, Jakaranda television programmes and adverts to promote health. Furthermore, radio and television are important for announcing events relating to health promotion in, for example, the Emfuleni area. The Gauteng Department of Health estimates that radio and television coverage of events relating to HIV/AIDS reached an estimated 10 million audience in February 2000 (Gauteng Provincial Department of Health 2000: 9).

Educational institutions are also important learning centres for health education. The hospital and clinic's health teams can maintain a good liaison with the school authorities. School children, for instance, have to be physically examined for symptoms of preventable diseases by their teachers with the help of primary health care personnel (Khokar 1992:19.). Sebokeng Hospital and Sharpville Community Health Centre can, for example, instil further confidence by training teachers in the Emfuleni area on aspects related to health education so that they can in turn disseminate knowledge to their scholars and students. In its final report, the Commission of Inquiry into Hospital Services (Commission) indicated that school children are the prime target of health education. The Commission believes that elementary teaching of hygiene and nutrition principles at primary school level is a worthwhile investment. The Commission therefore recommended that health promotion should receive high priority (South Africa 1986: 25).

The costs of ignoring the importance of communication, its techniques and available resources such as educational institutions can be enormous for the three spheres of government. According to Business Futures as quoted by Schwella (1992:2) the impact of AIDS is estimated to a possible death rate of 2,5 million people from AIDS by the year 2000. The Gauteng Provincial Department of Health (2000: 5) estimates that 23,1% of the total HIV infections occur in the Vaal Health Region. If even minimum health care is provided this will put a severe strain on health services provision. If present per capita cost per AIDS patient were extrapolated to 2,5 million possible future patients it would require three times the South African GDP. Currently, 2,8% of the GDP is spent on health. To prevent the spread of HIV/AIDS and other communicable diseases, a number of approaches to health promotion can be followed.

4.4.1 Approaches to health promotion

The Preamble to the *Constitution of the Republic of South Africa Act, 1996* commits the government to improve the quality of life of all citizens. Sections 24(a) and 27(1)(a) add to the above commitment as regards to primary health care. These two sections respectively provide for the right to an environment that is not harmful to health and access to health care services. To give effect to the foregoing provisions of the *Constitution of the Republic of South Africa Act, 1996* the Gauteng Provincial Department of Health and the Emfuleni Local Department of Health can use five approaches or ways of dealing with health promotion. These approaches are medical, behaviour change, educational, empowerment and social change.

4.4.1.1 Medical approach

The aim of the medical approach is to reduce morbidity and premature mortality. This approach targets the entire population or high-risk groups in the Gauteng Province. This approach relies on medical interventions which prevents ill health and premature death by immunisation and screening. It uses scientific methods such as epidemiology (the study of the pattern of diseases in society) (Naidoo & Wills 1994: 83-84.) Services provided by primary health care workers such as immunisation (South Africa Yearbook 1998c: 336) by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare can be regarded as a form of medical approach to health promotion.

The medical approach has its disadvantages. The approach ignores the social and environmental dimensions of health of for instance Emfuleni Local Authority. It also encourages dependence on medical knowledge. (Naidoo & Wills 1994: 84.) In view of the foregoing disadvantages, one can therefore infer that although the medical approach is an important component of the national health system, this approach is more related to curative care than primary health care.

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4.4.1.2 Behavioural change approach

The behavioural change approach aims to encourage individuals in the Gauteng Province to adopt healthy behaviours. For example, people can be persuaded to desist from smoking, adopt a healthy diet and regular exercise. This approach targets individuals although mass means of communication can be used to reach them. Many health care workers educate their clients about health through the provision of information and one to one counselling. (Naidoo & Wills 1994: 87.) The use of the three options (that is abstain, be faithful or condomise) in the street and school campaigns in the Gauteng Province can be seen as a plea to the young people to change their behaviour in order for them to be safe from HIV/AIDS (Gauteng Provincial Department of Health 2000: 8).

4.4.1.3 Educational approach

The purpose of the educational approach is to provide knowledge, information and to develop the necessary skills such as life-skills aimed at the youth so that they can make informed choices about their health behaviours. The school Life-skills Programme in the Gauteng Province, for instance, aims to provide learners with knowledge, values and skills to deal with everyday challenges and to promote and protect their own health (Gauteng Provincial Department of Health 2000: 10). The educational approach is based on a set of assumptions about the relationship between knowledge and behaviour: that by increasing knowledge, there will be a change in attitudes to, for example, the usage of condoms which may lead to changed behaviour. A teacher or facilitator normally leads educational programmes. (Naidoo & Wills 1994: 88.)

4.4.1.4 Empowerment approach

The empowerment approach help people in the Gauteng Province to identify their own concerns and gain the skills and confidence to act upon them. Instead of the expert role adopted by the

preceding approaches, the health promoter such as a nurse or a doctor becomes a facilitator. The health promoter acts as a catalyst, getting things going, and then withdraws from the situation. This approach may also be referred to as client centred or self-care approach. (Naidoo & Wills 1994:89.) The Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare can best use this approach in conjunction with the behaviour change and the educational approaches.

4.4.1.5 Social change approach

The social change approach acknowledges the significance of the socio-economic environment in determining health. This approach focuses on health policy or environment. The aim is to bring about changes in the physical, social and economic environment that will have the effect of promoting health. The approach targets groups and populations and is top-down in nature. (Naidoo & Wills 1994: 90.) An example of this approach can be the development of a policy that makes dumping of garbage on the street corner of townships such as Sebokeng in the Emfuleni Local Authority's area a punishable offence.

The foregoing approaches to health promotion are complementary in nature and can be used in various settings. For instance, the medical approach can be more effective in the prevention of polio whereby children in the Emfuleni area are immunised. Behavioural change and educational approaches can be used to minimise the spread of HIV/AIDS. One can therefore argue that all five approaches to health promotion can be useful in various settings and can be combined to achieve better results.

4.5 CORRUPTION AND THEFT

Heidenheimer in Bauer and Van Wyk (1999:57) describes corruption as, among others, the misappropriation (illegal appropriation of public resources for private gain) and the misuse of authority as a result of consideration of personal gain that need not be monetary. Fowler, Fowler

and Thompson (1995:1444) describe theft as the act or instance of stealing or dishonest appropriation of another's property with the intent to deprive him or her of it permanently. The definition of corruption and theft are closely related as the two phenomena relate to a wrongful action on the part of an official. Corruption in most cases involve people who know how to manipulate the control measures for their own benefit while theft involves both strangers and officials within institutions such as the departments of health

Sing and Wallis (1995:137) view corruption as a viral form of organisational cancer because it has a tendency of spreading from one official to another if it continues undetected and the concerned officials also "improve" their tactics to defraud the government. The possibility of stamping it out completely is remote since it involves people who know more than others about the control system for the financing of, for instance, the administration of primary health care services. This means that immediately anti-corruption measures are announced, the corrupt officials are also informed and thereby enabling them to suspend their activities until such measures are no longer strictly enforced.

Section 195(1)(a) and (b) of the *Constitution of the Republic of South Africa, 1996* provides that public administration in South Africa must promote and maintain a high standard of professional ethics and also be efficient, economic and effective in the use of resources. According to the aforementioned section, corruption and theft constitute unethical behaviour and leads to inefficient, uneconomic and ineffective use of resources such as finance and raw materials. It is for this reason that unethical behaviour is punishable in all government institutions including the Gauteng Province and the Emfuleni Local Authority.

In spite of the aforementioned sections of the *Constitution of South Africa, 1996* and actions which may be taken, stock theft in the departments of health on the three spheres of government is a major problem. The collaborative approach between the National Department of Health, its Inspectorate and the South African Police Services on curbing the theft of drugs has resulted in the cracking of a multimillion-rand syndicate, which operated from the Vaal Triangle in 1999. Various items

including illegally imported medicines, machinery used for repackaging and allocating batch numbers and expiry dates were seized. Evidence of recycling of expired medicines was also found (South Africa 2000b: 5).

As a result of uncovering the above-mentioned syndicate, the National Department of Health has attempted to improve control measures. For instance, an effective relationship has been established with the South African Police Service and the National Intelligence Agency. This has dramatically improved safety of employees and the stock. Furthermore, regular stock checks are undertaken to prevent the theft or loss of stock and equipment (South Africa 2000b: 5).

4.6 ROLE OF THE PRIVATE SECTOR AND NON-GOVERNMENTAL ORGANISATIONS IN THE ADMINISTRATION OF PRIMARY HEALTH CARE IN GAUTENG

The capacity and financial ability of the government to deliver primary health care services is limited. The establishment and involvement of both the private sector institutions such as Prime Cure and non-governmental organisations such as the Salvation Army in the primary health care sector is meant to assist the government where its services are found to be wanting. To get more private sector and non-governmental organisations involved in the provision of primary health care services the National Department of Health can propose tax incentives to the National Department of Finance which can in turn see to it that such proposals are tabled in the Parliament.

4.6.1 Private sector institutions in Gauteng

Some private sector institutions are currently actively involved with the HIV/AIDS prevention and control measures. The resources available to this sector should be mobilised accordingly in support of activities within the overall framework of the National Aids Plan. (South Africa 1997a: 112.) According to Saloojee (2000) private hospitals also offer various primary health care services within various settings in the Gauteng Vaal Health Region. She further argues that although private sector institutions play a significant role in the rendering of primary health care services, their contribution

has not reached its maximum potential. The somewhat low contribution of private sector institutions in primary health care can be attributed to lack of policies for public-private interface.

Although there are no policies to regulate private-public partnerships in matters concerning primary health care, institutions such as Prime Cure already play an important role in the rendering of primary health care services in the Gauteng Province. Prime Cure's target, for instance, is estimated at 12 million South African breadwinners who have no medical insurance and rely on the state for health care and medication. A superficial wound would, for instance, be treated for R8. 00 whereas a private doctor will charge up to R240. 00 (Taitz 1999:4). The rendering of a relatively cheaper service by Prime Cure and other private sector medical institutions will enable the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare to spare the scarce financial resources and decrease the influx of patients to public primary health care facilities.

It is estimated that one in every ten people in the South African labour force is HIV positive. The level of infection is expected to peak at about 25%(one in four) of the population, which means that the rate at which new infections take place will equal the death rate. Furthermore, it is estimated that in year 2005, 75% of the health budget will be consumed by direct health costs relating to AIDS (Cheminais, van der Waldt & Bayat 1998:118.) As indicated in section 4.4 of this chapter, 23.3% of the total HIV infections occurs in the Vaal Health Region where the Emfuleni Local Authority is situated. This implies that the prediction by Cheminais, van der Waldt and Bayat (1998: 118) will soon be a reality if private institutions do not increase their voluntary participation in primary health care. The wave of AIDS is already starting to hit the Gauteng Province and the Emfuleni Local Authority's area. The number of people dying in the province is increasing due to AIDS. By 2005, more people will die from AIDS than all other causes. Many of them will be between 25 and 49 years old. The only way to slow it down is to prevent new infections (Gauteng Provincial Health Department 2000: 3).

In view of the foregoing, one can say that Aids will impact on the public and private sector alike.

This implies that the private sector also needs to take a keen interest and collaborate with the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare in preventing diseases such AIDS. In 1999, the private sector demonstrated its commitment to Partnership Against Aids by developing HIV/AIDS programmes. The primary focus has been the sponsorship of community-based AIDS programmes. Furthermore, the South African Business Council on HIV/AIDS was established in February 2000. The South African Business Council is an umbrella structure that advises companies on HIV/AIDS policy (South Africa 2000b: 13).

In addition, individual private sector companies are also playing a significant role in the prevention of communicable diseases such as HIV/AIDS. BP South Africa in collaboration with the Gauteng Provincial Department of Health for instance, sponsors the Soul City television drama series that aims to raise awareness and educate members of the public in Gauteng Province about the dangers of HIV/AIDS. Soul City has been running successfully for five years. Eskom and other businesses such as insurance companies are also involved in AIDS education (South Africa 2000b: 13) in different parts of the Gauteng Province and Emfuleni area in particular.

Although HIV/AIDS programmes seem to be getting more attention because of the adverse consequences of the spread of the preventable disease, the private sector contribution in the Gauteng Province need to be channelled to health promotion in general. If both the departments of health and the private sector properly sponsor health promotion, the public will be educated on a range of other diseases as well.

4.6.2 Non-governmental organisations in Gauteng

Various non-governmental organisations, most of them voluntary, are involved in primary health care services in the Gauteng Province. The South African Red Cross renders emergency, health and community services, and offers training in first aid and home nursing. Hospices are centres established to improve the quality of life of the terminally ill through care, support and love. Nursing personnel at hospices in the Emfuleni area, for instance, look after the physical, social,

emotional and psychological needs of the patients and their relatives (South Africa Yearbook 1998c: 343-344).

According to Clark (1990:29) NGOs such as the Catholic Relief Services were initially engaged in relief work. They gradually shifted their attention to Third World countries such as South Africa and also broadened it to include welfare activities-a natural extension of relief. Saloojee (2000) further points out that non-governmental organisations in the Gauteng Province assist in programmes such as HIV/AIDS prevention, mental health and nutrition.

NGOs depend on a variety of sources that include the national and Gauteng departments of health for purposes of funding. The *White Paper for the Transformation of the Health System in South Africa* (1997a: 189-190) provides the following guidelines for funding NGOs with specific reference to primary health care:

- the NGO concerned should address national and/or provincial priorities such as HIV/AIDS;
- it should be non-racial and non-sexist;
- it should be non-profit making;
- it should be accountable in terms of its mission to serve the interest of the community of for instance Emfuleni;
- the NGO concerned should adhere to the RDP's principles such as integration and sustainability, nation building, peace and security, linking of reconstruction to development, and democratisation of the country;
- it should be a legally instituted body;
- it should be duly constituted, have a functioning committee and be managed by a management committee;
- it should have a potential and have a proven track record for executing the proposed project such as health promotion in the Emfuleni local area;
- the NGO concerned should be able to provide evidence of its financial stability, together with a summary of its current financial situation;

- any institution involved in the provision of funding to the NGO should be declared.

The Gauteng Provincial Department of Health does not have enough resources to satisfy all primary health care needs of the people of the Gauteng Province. This kind of situation requires the private sector institutions and non-governmental organisations to be pro-active and intervene in those areas that are not adequately covered by the Gauteng Provincial Department of Health. To assist NGO's in the identification of services which require their intervention, the Gauteng Provincial Department of Health in collaboration with National Department of Health and local authorities such as Emfuleni can draw a list of such services and areas where they are needed. Such a list should then be forwarded to all NGO's active in primary health care in the Gauteng Province and Emfuleni local area. This will avoid the duplication of services already rendered by the three spheres of health departments.

4.7 SUMMARY

The role played by the Gauteng and other provincial departments of health is outlined by the *Constitution of the Republic of South Africa Act, 1996.* The Gauteng Provincial Department of Health serves as a link between the National Department of Health and the Emfuleni Department of Health and Welfare in matters pertaining to primary health care. The district health system brings the administration of primary health care closer to local communities such as people within the area of jurisdiction of the Emfuleni Local Authority. This will encourage citizen participation. Furthermore, if the five approaches to health promotion are implemented, the spread of various diseases such as AIDS and tuberculosis will be averted. Corruption and theft are ethical dilemmas that threaten the sustainability of primary health care services and it is therefore necessary for control measures to be revised continuously. The prevention of diseases should, however, not be seen as the function of the public sector alone. It is therefore necessary for the private sector institutions and non-governmental organisations to be actively involved in health promotion. Lastly, the Gauteng Provincial Department of Health needs the Emfuleni Department of Health and Welfare to realise its objectives. The following chapter focuses on the role of the Emfuleni Local Authority

in primary health care.

CHAPTER 5

PRIMARY HEALTH CARE SERVICES PROVIDED BY THE EMFULENI LOCAL AUTHORITY

5.1 INTRODUCTION

The Gauteng Provincial Department of Health as described in the previous chapter is part of the second sphere of government that relies on local governments such as Emfuleni Local Authority for the delivery of primary health care services. In this chapter, the role of the Emfuleni Local Authority and in particular the Emfuleni Department of Health and Welfare in rendering primary health care services to people in the Emfuleni area of jurisdiction is described. In this chapter, focus is on areas and institutions that were found to have specific problems during the research. These areas and institutions are clinics, hospitals, finance, personnel, security, urbanization, the role of traditional healers in primary health care, community participation, and obstacles encountered in community participation. The above mentioned areas and institutions are described and investigated with a view to finding practical solutions to problems such as the insufficiency of resources like finance and personnel, theft and corruption, the under-utilization of traditional healers in primary health care services and citizen apathy. This chapter starts with the description of the Emfuleni Local Health Authority in order to put it into perspective.

5.2 EMFULENI LOCAL AUTHORITY IN PERSPECTIVE

Local authorities such as Emfuleni are the third sphere of government and administration in South Africa as regards authority and the rendering of a number of services that include primary health care services. The Emfuleni Local Authority, which is situated in the Gauteng Province, also forms part of this sphere of government and administration. Because of this organizational arrangement, the Emfuleni Department of Health and Welfare amongst others performs its own functions within the parameters of policies approved by the National Department of Health and the Gauteng

Provincial Department of Health.

Section 156(1) of the *Constitution of the Republic of South Africa, 1996* confers executive authority to the Gauteng and other provincial governments in respect of local government functions listed in part B of Schedule 4. Municipal health services are amongst those services. In addition, section 44(1) of the *National Health Bill, 2001* mentions environmental health services, promotive and preventive health services as the responsibility of local governments such as Emfuleni Local Authority. It is for this reason that the Emfuleni Local Authority has established its own Department of Health and Welfare and has a number of clinics responsible for the delivery of primary health care services.

The demarcation of local boundaries in South Africa reduced the number of local authorities from 843 to 284 in December 2000. In terms of the *Constitution of the Republic of South Africa Act, 1996* local authorities in South Africa are classified into category A, B and C. The Emfuleni Local Authority is one of the district municipalities in the Gauteng Province. The Emfuleni Local Authority include areas such as Vanderbijlpark, Bophelong, Boipatong, Sebokeng, Vereeniging, Sharpville, Evaton, Beverly Hills, Palm Springs, and Rustevaal (Mashigo 2002).

The Emfuleni Local Authority is established as part of the Sedibeng District Local Authority in terms of section 10 of notice 6200 of 2000. The Emfuleni Local Authority is a category B local authority in terms of the *Local government: Municipal Structures Act, 1998* (Act no 117 of 1998). The Emfuleni Local Authority consists of 43 Wards and 85 councilors, 42 councilors are proportionally elected while 43 are ward councilors (Gauteng notice 6200 of 2000).

The 85 councilors mentioned above constitute the Emfuleni Local Council which is the legislative institution for Emfuleni in matters pertaining to, amongst others primary health care. Diagram 6 on page 88 further shows that the municipal manager is the link between the Strategic Manager for Development and Planning and the Council. The Strategic Manager for Development and Planning is responsible for a cluster of departments that include the Department of Health and Welfare headed

by a Manager (diagram 4 below).

The Emfuleni Local Authority is divided into two health districts. In the two districts, there are twenty clinics, two community health centers and two public hospitals. Community health centers and hospitals are administered by the Gauteng District Support Services (Provincial Regional Office) (Mashigo 2002).

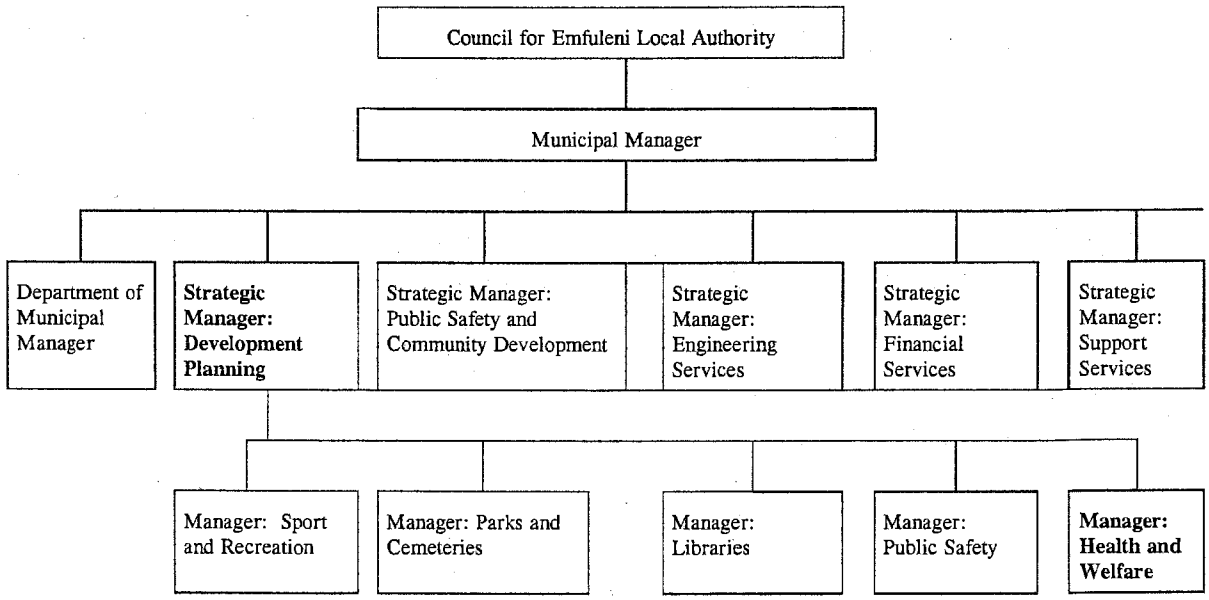

Diagram 6: Organizational structure for the Emfuleni Local Authority
Source: Emfuleni Local Authority

In addition to the foregoing broad organizational structure for the Emfuleni Local Authority, a structural/functional diagram for the Emfuleni Department of Health and Welfare is provided on page 89.

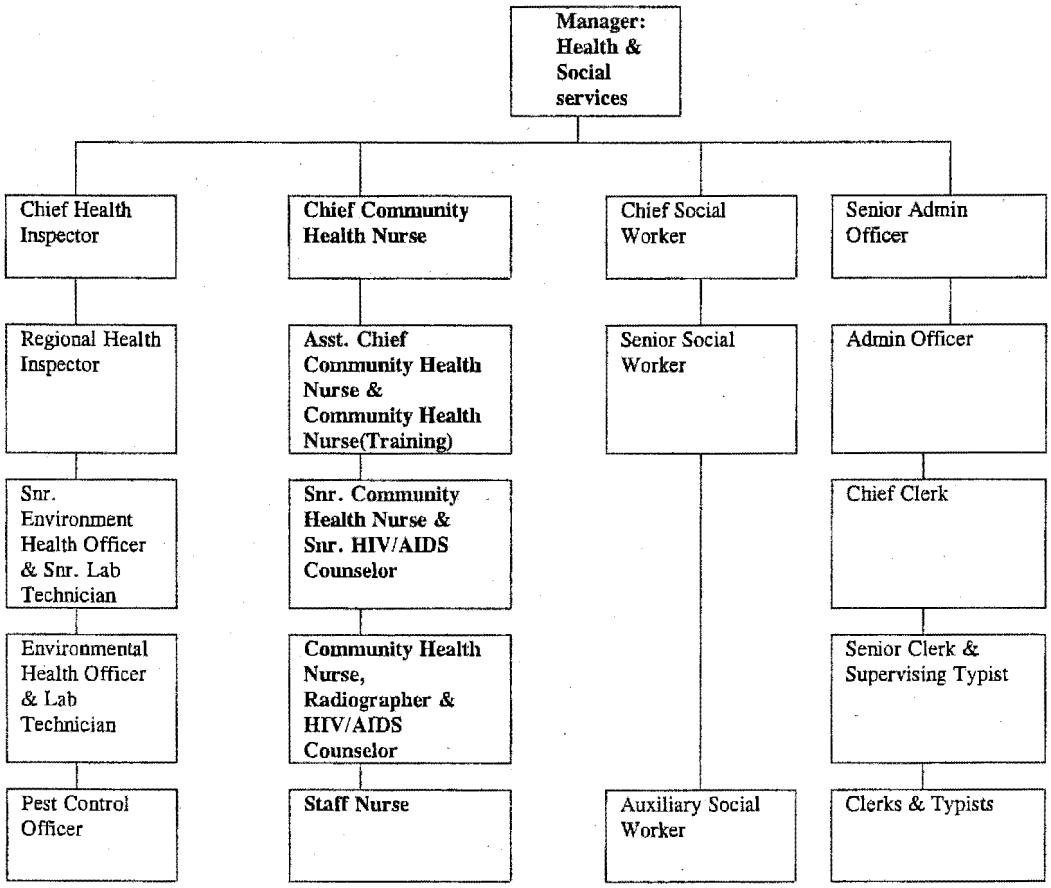

Diagram 7: Structural/functional diagram for Emfuleni Department of Health and Welfare
Source: Emfuleni Department of Health and Welfare

A local authority such as Emfuleni must render specified services to prevent amongst others, the development of unhygienic conditions. Section 20 of the *Health Act, 1977* (Act 63 of 1977) delegates the responsibility to keep the environment in a hygienic and clean condition to local authorities. In the event that the local authority such as Emfuleni fails to provide prescribed services, Cloete (1997:102) states that the Minister of Health, after consultation with the provincial authorities such as the Member of Executive Council for Health, can relieve the local authority of its duties to provide services. The National Department of Health will then render services such as primary health care and the costs incurred will be recovered from the Emfuleni Local Authority.

For the Emfuleni Local Authority to perform its duties in terms of the aforementioned legislation,

it has established hospitals and clinics that are described in the section hereunder.

5.3 ROLE OF HOSPITALS AND CLINICS IN THE RENDERING OF PRIMARY HEALTH CARE SERVICES

In 1998, an accounting firm was requested by the National Department of Health to investigate the management of public hospitals and analyze their cost structures. The results were unsatisfactory hence the Director-General of the National Department of Health stated that a medical doctor who is not trained in disciplines such as management, information technology, human resources and financial management should not be appointed as a chief executive officer of a hospital. This suggests that people with specialized skills are needed for the administration of hospitals and primary health care facilities such as clinics. However, the Director-General of the National Department of Health adds that it is important that a medical doctor becomes part of the management team as he/she can understand the practical functioning of hospitals (Mazwai 1999:1).

There are two public hospitals, that is, Sebokeng and Kopanong within the Emfuleni Department of Health and Welfare's area of jurisdiction. Kopanong Hospital is more concerned with primary health care services such as personal health and preventive services. Sebokeng Hospital does not render primary health care services at all as it is concerned with curative care (Madonsela 1999).

Madonsela (1999) points out that clinics now assume some of the duties such as communicable and non-communicable diseases prevention which were previously performed by hospitals. However, there appears to have been a lack of co-ordination when hospitals such as Sebokeng stopped rendering primary health care services because clinics within the Emfuleni Department of Health and Welfare's area of jurisdiction were not informed about the possible increase of patients in advance. Clinics were as a result of the lack of co-ordination between themselves and hospitals expected to deal with a growing number of patients. Their financial and human resources capacities were not improved to be in line with the influx of patients.

The National Department of Health and the Gauteng Provincial Departments of Health are permitted by section 156(4) of the *Constitution of the Republic of South Africa Act, 1996* to devolve powers and functions to local health departments such as Emfuleni Department of Health and Welfare. The aim of delegating powers is to improve the effective management of services such as primary health care. This process is beset with problems. The delegation of powers and functions, for instance, occurs without the financial and administrative capacity required. (South Africa 1997: 32-33.) This process results in unfunded mandates that strain the Emfuleni Local Authority's resources and impact negatively on primary health care service delivery (Madonsela 1999).

In addition, Slabber (1993:15) points out that management styles must be adjusted to include health workers and communities in the various facets of health management. The process of consultation should include various public institutions such as hospitals and clinics, members of the public and the private sector such as the Iron and Steel Corporation Ltd. (Iscor) in the Emfuleni Local Authority's area. The determination of primary health care services need the identification of priority issues, the implementation of plans and the monitoring of services are some of the relevant areas for consultation. Management should be maximally decentralized and decision-making devolved to the lowest possible level of for instance the facility manager at a clinic. Only if decision-making is vested at clinic level can health managers be held responsible for their actions. If final primary health care policies, strategies, plans, and decisions in, for instance, Emfuleni Department of Health and Welfare are not passed down from the top hierarchical structures, initiative at operational level is inhibited and creative thinking discouraged.

Decisions in the Emfuleni public health sector have traditionally been made at a centralized level. Managers at the lower levels such as facility managers have not been given the authority to make important decisions such as those that relate to the budget. However, as effective and efficient use of scarce resources is becoming one of the most important factors in the health sector (such as the Emfuleni Local Authority), managers at all levels will have to take responsibility for decisions they take (Planact 1997: 55). This will require drastic changes in the organizational structures, culture, and managerial styles. Implicit in all this centralized decision making is the need for managerial

training throughout the primary health care system in Emfuleni.

Since the introduction of free primary health care services in 1996 clinics are seeing more patients while there are many instances where the movements of patients away from hospital outpatient departments to clinics has not been accompanied by a transfer of staff. This increase in patient numbers in clinics has led to some compromise in the quality of health care at this level (Health Sector Strategic Framework 1999-2004, available at http://www.doh.gov.za/docs/policy/framework/chap03.html 10/10/2001).

In addition to the foregoing managerial deficiencies, the lack of transport is a problem that inhibits the rendering of primary health care services in the Emfuleni townships such as Sebokeng and Bophelong. For a primary health care approach to succeed there should be continuous contact between health officials and the community. Such contact should be inside and outside the primary health care centers in Emfuleni. The latter form of contact depends on the availability of transport. It is for this reason that there are no more home visits for patients by nurses. The lack of transport also makes it difficult for nurses to visit schools for purposes of health promotion. (Motloba 1999).

5.4 FINANCE IN THE RENDERING OF PRIMARY HEALTH CARE SERVICES BY THE EMFULENI LOCAL AUTHORITY

All local authorities need money to render services that include primary health care services. This is also applicable to the Emfuleni Local Authority. Section 214(1) of the *Constitution of the Republic of South Africa Act, 1996* provides for the equitable sharing of revenue collected nationally among the national, provincial and local spheres of government in terms of an act of Parliament. In addition Craythorne (1997:391) states that municipal authorities derive their income from a narrow tax base which include property rates, levying of fees and charges to pay for services.

While the tax base is limited, the Emfuleni Local Authority and other municipalities experiences resistance regarding the payment for services. The money owed Gauteng municipalities including

the Emfuleni Local Authority by residents in 1999 was R6 billion (Kroukamp 2001: 34). The non-payment for services worsens the financial problems of the Emfuleni Local Authority even further. Limited financial resources impacts on the number of primary health care personnel to be employed and the quality of their services.

5.5 PERSONNEL

The provision of adequately skilled, compassionate, caring and competent health workers is essential for the delivery of a reasonable quality health service (Planact 1997: 55) which includes primary health care in the Emfuleni Local Authority. Shortage of personnel is a serious problem hampering the delivery of primary health care services in the Emfuleni area. Sharpville Community Health Center, for instance, requires seventeen professional nurses but has only eight (Madonsela 1999). Furthermore, Motloba (1999) concurs and states that the situation becomes even worse when some of the available few nurses have to attend courses, report sick, are on vacation or study leave.

In view of the foregoing, one of the more demanding challenges facing the Emfuleni Department of Health and Welfare is the recruitment and retention of personnel given the attractive salary packages and conditions of service offered by the private sector and foreign governments. It is estimated that 65% of the financial resources allocated to the South African health sector are predominantly spent on human resources. This implies that there is very little room for additional financial incentives such as the expansion of primary health care services. (Health Sector Strategic Framework 1999-2004, available at http://www.doh.gov.za/docs/policy/framework/chap03.html 10/10/2001).

The situation outlined above calls for the need to explore the use of non-financial incentives to attract and retain scarce health professionals such as doctors and nurses. The introduction of non-financial incentives require the National Department of Health to develop proposals and secure agreements with labor unions under the auspices of the Health and Welfare Bargaining Chamber (Health Sector Strategic Framework 1999-2004, available at

http://www.doh.gov.za/docs/policy/framework/chap03.html 10/10/2001).

The insufficiency of personnel such as cleaners and nurses can precipitate death among patients in Emfuleni health facilities. Smith (1999:3) reports that four babies at the Chris Hani Baragwanath Hospital died of Klebsiella, a disease that results from poorly cleaned hospitals. Furthermore, he writes that only four nurses were on duty to care for 35 babies in an intensive care unit while the minimum ratio should be one nurse for every two babies. Smith's argument further points to the acute shortage of nurses in the Gauteng Province, a situation as previously stated also applicable to the Emfuleni Local Authority.

It is estimated that for a population of 20 000, a total of 54 primary health care nurses would be needed. As of 31 December 1997, 2678 nurses had completed either a diploma or certificate course related to clinical nursing science, health assessment, treatment and care at nursing colleges around South Africa. (Strasser & Gwele 1998: 88.) This number of nurses with some form of primary health care qualification (if they were all working in public clinics) would be able to support a population of only 10 million. These figures illustrate the urgent need for more primary health care nurses if the primary health care service package is to become a reality (Strasser & Gwele 1998: 88) in South Africa and at the Emfuleni Local Authority in particular.

Zwarenstein and Baron (1992:34) further argue that it is not enough to provide training alone. It must have rewards and incentives for excellence and advancement of skills needed in the rendering of primary health care services. Rewards and incentives for excellence are lacking in South Africa and the Emfuleni Local Authority, and unless they are developed the training programs will not attract the best candidates.

In-service training is needed for health sector employees at all spheres of government and administration including the Emfuleni Local Authority. Managerial employees need the knowledge and skills to be competent managers, while professionals such as nurses and doctors providing primary care services or technical support should also be trained to adapt to the changing

environment. Training should also focus on fear and resistance to changes (Zwarenstein and Baron 1992:34).

South Africa has experienced a substantial brain drain of health professionals such as nurses and doctors, primarily to North America and Europe. It is estimated that the Emfuleni Local Authority loses nurses at a rate of plus minus 2 per month. Most of these nurses go to the United Kingdom (Mashigo 2002). South Africa has also witnessed an internal drain as professionals leaving the public health sector for more lucrative private sector employment (Beatie, Rispel & Booysen 1993: 931). The private sector attracts many skilled workers by offering good salaries and working conditions (Planact 1997:55). Pela (1999: 2) reports that between 70 and 100 doctors emigrate from South Africa every year. The Emfuleni Local Authority has not reported a substantial loss of doctors to other countries.

Nurses employed in the Middle East, for instance, earn a minimum basic salary of R167 000 a year. This salary is tax-free and does not include overtime remuneration. Those who are employed in the United Kingdom earn over R126 100 a year plus overtime, with subsidized accommodation, free ongoing training and opportunities to travel. On the contrary, a professional nurse in the South African public service earns between R47 617 and R53 362 a year and senior professional nurses on level seven earns between R59 308 and R65 289. (Hills 1999:11.)

Nurses who are accepted in foreign countries receive one-year contracts and 70 percent of them can renew their contracts for a maximum of three years. The departure of nurses to foreign countries may have positive results in future. Furthermore, it is pointed out that nurses who come back have gained more skills, experience of working in hospitals with sophisticated medical equipment, access to continuing education and working in an international community. (Hills 1999:11.)

Contrary to the foregoing positive views regarding the emigration of nurses, the Chairperson of South African Medical Association's Full Time Practice Committee as quoted by Pela (1999:2) describes the loss as tragic- not only because the resources invested in training a nurse for the

benefit of someone else, but also because of the doctor's and nurse's familiarity with local conditions.

In addition, Keeton (1999:11) states that the quality of services is affected by personnel shortages. When personnel feel demoralized because of being overworked and not getting commensurate incentives, patient care is affected negatively. Stuckey (1999:3) reports for instance that patients at Empilisweni Clinic in the Emfuleni Local Authority have to come as early as six o'clock in the morning and wait in the queue until eleven o'clock to be attended to. The reason for the long queue is the shortage of personnel and the inability of patients to afford private medical care. Whilst the primary health care system is nurse driven, there is a need for medical doctors to provide certain services at the primary health care level and to provide the necessary backup to the nursing cadre (South Africa 1998b: 10)

The community health worker is a new feature of the South African health team that complements nurses and doctors. Community health workers are peers and understand the context of the community of for instance, Emfuleni. Community health workers need to work with a supervisor such as a medical doctor and nurse. According to Zwarenstein and Barron (1992:33), one community health worker in South Africa and Emfuleni in particular can provide primary health care services to 2000 people (250 homes) with reasonable continuity of care, and with a slowly developing personal relationship with the concerned families. The community health workers deal with minor ailments and should refer his/her patients with serious ailments to a specific professional medical person such as a nurse or doctor in the local facility such as a clinic or community health center in for instance the Emfuleni area. In addition, other roles of the community health workers are general counseling, advise on sexually transmitted diseases and AIDS, and screening for serious social and physical problems such as child/spouse abuse, alcohol abuse, tuberculosis and mental health problems.

The concept of self-help should be emphasized at all times and especially in the Emfuleni Local Authority where there is an acute personnel shortage. Motloba (1999) states that one of the roles

of the community health workers is to visit schools. In addition to the community health worker, Zwarenstein and Barron (1992:33) state that the health team may use the services of volunteer workers. The advantage of using volunteer workers is that they do not need any remuneration. It could, however, be a risk to use volunteer workers who are not knowledgeable in the field of primary health care. The foregoing therefore implies that volunteer workers should be trained and thereafter perform their functions under the supervision of a professional medical person such as a nurse or a doctor.

Apart from personnel shortages, the quality of services can be adversely affected if equipment and medicine are stolen. This implies that security is an important component of primary health care delivery in the Emfuleni Local Authority.

5.6 SECURITY

Madonsela (1999) mentions security as one of the major problems faced by the Emfuleni Department of Health and Welfare in the rendering of primary health care services. A number of burglaries were reported by various clinics within the area of jurisdiction of the Emfuleni Department of Health and Welfare. Burglaries led to the disappearance of important equipment such as refrigerators and heaters. Medicine is also an easy target for burglars. Theft seems to be a serious problem hence the Gauteng Member of Executive Committee responsible for Finance as quoted by Smith (1999: 3) condemns the looting of bed-linen and medicines from hospitals in the Gauteng Province and at hospitals within the area of jurisdiction of the Emfuleni Local Authority.

The theft of important equipment and medicine impairs the delivery of primary health care services by the affected clinics. To support the foregoing argument on theft, Planact (1997:5) reports that clinics around the country are unable to give immunization because they do not have refrigerators to store the vaccines. This situation is often witnessed at Emfuleni Local Authrity whenever equipment such as refrigerators, medicines and linen are stolen.

5.7 URBANIZATION

According to Cloete (1997: 5) the word urbanization can be used to refer to a process by which people move to and become concentrated in urban areas referred to as villages, towns, and cities. This definition implies that people move from rural to urban areas such as Emfuleni. This movement puts the Emfuleni Local Authority in a difficult position as it does not have control over the number of people coming into its areas of jurisdiction. In turn, local authorities such as the Emfuleni Local Authority are required to cater for needs such as health and primary health care in particular to such people on humanitarian grounds.

Berstein as quoted by Griffiths (1991:152) projected that by the year 2000 almost 25% of the South African population will live in PWV region (now called Gauteng Province) which occupies under 2% of the national land. This implies that public health resources in the Emfuleni Local Authority are under more pressure as a result of urbanization and the increasing population.

The main reason cited by Craythorn (1997:115) for urbanization relates to economic conditions. Griffiths (1991: 154) concurs with Craythorn on this view. Furthermore, Griffiths (1991:154) states that people migrate in order to join relatives and friends who have previously migrated to urban areas. Most people in the Emfuleni Local Authority moved from rural areas to join breadwinners who are employed by factories and industries such as the Iron and Steel Corporation in Vanderbijlpark, while job seekers migrate with the hope of finding employment. Families moving from rural areas to urban areas are always faced with the problem of finding houses. Hostels and informal settlements are the destiny of people migrating to the Emfuleni Local Authority's area of jurisdiction. Due to the fact that these families are relatively poor, they cannot afford to buy housing; they construct dwellings from all sorts of material. The land used for this purpose belongs to either the Emfuleni Local Authority or a private individual. According to Cloete (1997: 7) informal settlements are not formally planned hence essential services such as health, clean water and rubbish removal are in most cases not provided.

The relative poor conditions under which people in informal settlements and hostels live suggests that they cannot afford health services provided by private medical practitioners. It therefore follows that the local authorities such as Emfuleni has to ensure that people in informal settlements receive either free primary health care services or they have to pay a nominal fee.

Furthermore, Madonsela (1999) states that the proliferation of informal settlements within the Emfuleni Local Authority area of jurisdiction have serious consequences on health such as diseases resulting from the use of contaminated water. Access to infrastructure and services such as water, sanitation, electricity, and housing have both direct and indirect effects on health. For example, the lack of clean water can lead to diseases such as diarrhea (which kills many children), bilharzia and typhoid (Planact 1997:53). In addition Hilliard (1992: 169) states that people moving to urban areas can neither afford electricity or it is not available and they resort to the use of coal for making fires for cooking and heating. Coal fires increase smog and atmospheric pollution and could lead to a higher incidence of lung diseases such as tuberculosis.

5.8 ROLE OF TRADITIONAL HEALERS IN RENDERING PRIMARY HEALTH CARE SERVICES

The South African health system, as indicated in section 3.3, evolved from both western medicine on the one hand and the various African cultures with their traditional tribal medicine on the other. Traditional healers should also be seen as important role players in the rendering of primary health care services such as health promotion in the Emfuleni Local Authority. They should also concentrate on prevention rather than cure. The significance of traditional healers is often neglected when primary health care policies are developed. Traditional healing in South Africa consequently continues to function informally and to the detriment of patients as a result of for instance the use of unsterilized razors that could transmit HIV. Although, the formalization of this practice cannot be an answer, government intervention by introducing a code of good practice or educating traditional healers about the basic principles of primary health care should make a difference. Traditional healers are often the first people consulted by most black patients (Progress since

Amsterdam: South Africa, Available at http://www.archives.healthdev..net/stop-tb/msgooo28.html)8/11/2001).

The Traditional Healers Forum has been established to plan for an Interim Traditional Healers Council (Annual report of the Department of Health 2000-2001, available at http: www/96.36.153.56/doh/docs/legislation-f.html 2001). Furthermore efforts are still underway to register qualified healers and help them gain professional recognition, which will bring them the financial benefits of their patients' medical schemes. There are estimated 265 traditional healers associations in South Africa and they wish to play a more prominent role in the country's health system (http://www.fingaz.co.zw/fingaz/2001/june/june14/1936.shtml 2001).

Traditional healers in the Emfuleni Local authority are still not formally recognized in the provision of primary health care. However, attempts are being made to educate and interact with them at clinic level.

5.9 COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

The White Paper on the Reconstruction and Development Program (ANC 1994: 24) emphasizes primary health care services. It further states that providers of health services must be accountable to the local communities they serve. This is done through a system of committees and the district health authorities that must be part of the democratically elected local government (ANC 1994: 24). Furthermore, people with their aspirations and collective determination are recognized as the most important resource. The RDP relies on the public to drive the process of meeting basic needs such as primary health care services (ANC 1994: 3).

According to Streefland and Chabot (1990: 17) community participation has been seen as a mechanism that ensured that health care beneficiaries became involved in the decision-making process of health care priorities and the resource allocation. In line with the Government's decentralization policies and the provisions of schedule 4 and 5 of the *Constitution of the Republic*

of South Africa Act, 1996 with respect to the devolution of authority and responsibilities to provinces and local governments, the National Department of Health has adopted the district health system as a vehicle for the delivery of primary health care services in South Africa. This system is designed to bring decision-making closer to communities so that community involvement can be maximized. The Gauteng Provincial Department of Health for instance has 25 health districts (South Africa 1998b: 6-7) which include Emfuleni.

Community participation at the initial stage of policy-making is needed since the outcome of every policy-making process affects the quality of services rendered to all the citizens. It is for this reason important for every citizen to be afforded an opportunity to make inputs that will eventually shape primary health care services rendered by departments of health on the three spheres of government and the Emfuleni Local Authority in particular.

According to Dennill et al. (1995: 69), a prerequisite for community participation is that the government should have a clear, stable and supportive national policy and political framework. In South Africa, for instance, legislation provides for public access to information held by government institutions (De Giorgi 1999: 26). This includes information on primary health care services required by the community for informed participation. Protection of individual and minority group rights and interests is also necessary. Complicated and difficult public decisions should be delayed to ensure understanding by the community. (Brynard 1996:44-45.) Moreover, an atmosphere of trust should exist between the community and officials of the Emfuleni Departments of Health and Welfare.

Community participation in the Emfuleni Local Authority requires the development of partnerships between health care providers and the departments of health at the three spheres of government and the community. Such a partnership generates health care strategies that empower a community and it is one in which health professionals are facilitators in community participation.

The involvement of all people has been reiterated in the White Paper on the Reconstruction and

Development Program that states that the people with their aspirations and collective determination, is the most important resource that needs to be tapped continuously. The RDP is focused on people's most immediate needs, and it relies, in turn, on their energies to drive the process of meeting their needs. Regardless of their race, sex or whether they are rural or urban, rich or poor, the people of Emfuleni must together shape their own future in the administration of primary health care services. The community must be made aware that the efficient administration of primary health care services is not only about the delivery of goods and services to passive citizens, but it is about active involvement in the primary health care policy-making process and empowerment. (Okoro 1995:145.)

According to Hildebrandt (1996:156) partnerships occur when professionals share information and decision-making with the community in ways that result in neighborhoods and communities where people are effective participants in the administration of their own primary health care services. Effective community health care services promote self-reliance and can give the Emfuleni community a sense of control over their lives. Community participants develop the capacity to appraise their needs and determine priorities. In this way, the people of the Emfuleni Local Authority can identify and mobilize available assets to develop sustainable health programs.

Participation of the community helps public health officials and political office bearers to expand their knowledge regarding primary health care problems by listening to community members. Active participation of the Emfuleni community increases the likelihood that programs and projects are based on sound decisions and supported by the majority of members of the public. To empower the community, public health officials must be willing to "give up" their authority, accept agenda setting by the community and work within the community to meet set goals. Communities, in turn, must try to involve a broad spectrum of residents and be committed to working for the good of all. (Hildebrandt, 1996:159.)

5.9.1 Obstacles in community participation

Section 195(1)(e) of the *Constitution of the Republic of South Africa Act*, 1996 provides that the people's needs must be responded to, and the public must be encouraged to participate in policy-making. Although the foregoing section encourages and guarantees community participation, there are a number of obstacles that impede on the ability or willingness of the community to participate in policy-making for the administration of primary health care services. It is important for the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Departments of Health and Welfare to be aware and deal with the obstacles outlined below.

5.9.1.1 Professional resistance

Professional resistance manifests itself when medical and administrative personnel are not prepared to dispense their autonomy and involve the community in the decision-making process pertaining to primary health care policies. Health professionals are often not eager to relinquish power and control, or to engage in activities that will interfere with their status and privileges (Dennill et al. 1995:62). The unwillingness to share decision-making power by officials is also a problem in the Emfuleni Department of Health and Welfare. Most clinics and hospitals in the Emfuleni Local Authority for instance, do not have suggestion boxes that could enable members of the public to air their views and dissatisfactions about the delivery of primary health care services.

Health officials dislike the idea of self-help and the transfer of important health matters to the community. However, a gradual shift in attitudes has been observed since the Alma Ata Declaration. Community participation will not be successful unless the professional members of the multi-disciplinary health team accept the community as active members of the team, and not as a threat to their positions (Dennill et al. 1995:65).

5.9.1.2 Passivity of community

Most members of the community in the Emfuleni Local Authority only show a keen interest in the administration of primary health care services when the media reports about irregularities or financial mismanagement by members of health departments. Vosloo (1991:260) asserts that many people do not avail themselves of their opportunities to influence public affairs because of inertia or indifference. This implies that people ignore or are unaware of their constitutional rights and responsibilities to be actively involved in the policy-making process. Furthermore as Khokar (1992:37) points out, the majority of people are more concerned with cure, and approach the primary health care centers or the practitioners in cases of illness only.

The passivity of the community on participation can be observed at the local sphere of government. People in the Emfuleni Local Authority, for example, are normally invited by ward councilors to attend meetings that present them with an opportunity to influence public policies on a variety of issues including primary health care services. However, very few people attend such meeting (Madonsela 1999). Poor attendance of meetings called by councilors can be attributed to councilors inability to deliver services promised to members of the public during election campaigns. Furthermore, poor attendance can be an indication of the community's level of interest in public affairs.

5.9.1.3 Lack of strong political will

Politicians in Emfuleni may also contribute to the lack of participation in cases where they only pay lip service to community participation. They may seem not to be enthusiastic to develop local leaders at different levels, or provide outright support to community activities through their own participation. In addition, there is also a belief that at times politicians use community participation as a ploy to achieve their own goals (Dennill et al. 1994: 63). The proliferation of such a notion will deter communities from participation.

Madonsela (1999) cites the abrupt shifting of most primary health care services from the hospitals to the clinics as a lack of consultation. As a result of this decision, members of the public had to be turned away from hospitals to utilize clinics. Clinics were also unprepared for a sudden increase in the number of patients. This is an indication that politicians have to consult both the community and the officials responsible for rendering primary health care services when important decisions are made.

5.9.1.4 Lack of administration and communication skills

The administration of primary health care services by the Emfuleni Department of Health and Welfare requires definite operational skills and communication skills. The heterogeneity of the Emfuleni population poses a challenge to managers with regard to their understanding of community dynamics. The eleven official languages mentioned in section 6(1) of the *Constitution of the Republic of South Africa Act, 1996* and the level of illiteracy compounds the problem further.

The fact that South Africa has eleven official languages implies that every person in Emfuleni can rightfully expect to be addressed in the language that he/she understands. The use of all languages simultaneously is, however, not practical given the financial constraints. To communicate information regarding the prevention of communicable diseases such as AIDS to an illiterate audience, the Emfuleni Department of Health and Welfare for instance, can use some of the eleven radio stations which speak languages predominantly spoken in the Emfuleni Local Authority in order to ensure that every person gets the message of health prevention. In addition, it is important for managers involved in the administration of primary health care services to understand the culture, beliefs, norms, values and prejudices of the community and then plan their interaction with the community accordingly.

5.9.1.5 Lack of logistical support and co-ordination mechanism

Dennil at al. (1995:62) cites financial and geographic mal-distribution of health care services as a

problem in community participation. The distribution of health facilities throughout the Emfuleni local area is good in principle although it has logistical, co-ordination and financial implications. The involvement of the community implies that each member of the community should have the right to documented information such as the policy for the implementation of the District Health System. To provide each member of the Emfuleni community with a free copy of a draft policy is also costly. This implies that effective community participation may be impaired by the scarcity of financial resources.

5.9.1.6 Lack of innovation

Innovation regarding primary health care policies is closely related to interest and concern by the public. If members of the public are not interested in participation, it will be difficult to gauge the extent to which the Emfuleni community can innovate. The National Department of Health has established a Health Information Center responsible for managing the National Health Information System. All people including those in Emfuleni and their Local Authority must use the National Health Information Center. However according to Mathekga (1999) personnel in the National Department of Health and researchers mostly visit the Health Information Center. This can be attributed to lack of knowledge and interest that in turn impede innovation on the part of the community.

5.9.2 Conflict of interest in community participation

Members of the public in the Emfuleni Local Authority will always have different views and perceptions regarding a particular aspect of the primary health care policy. For example, one interest group can argue that money set aside for health promotion should be allocated to non-governmental organizations to educate people about the prevention of communicable diseases. On the contrary, another interest group can argue that existing educational institutions can be used in lieu of non-governmental organizations and thereby saving money.

In a heterogeneous country such as South Africa conflict of interests is inevitable. Brynard (1996:41) and Clapper (1996:55) concur that conflict in community participation will always occur. The question that may be asked is how should the government ensure that conflict regarding policy issues are dealt with to the satisfaction of the parties involved. To reconcile differences Clapper (1996:55) suggests that the principle of majority rule- that fifty plus one people be in favor of the decision should be invoked. This principle sounds democratic, however, in practice it may be difficult to implement because most public policies are based on needs and expectations of the public. Furthermore, this principle requires simple use of numbers that need voting or referenda that may be costly.

The Emfuleni Department of Health and Welfare is despite all conflicts expected to base their policies on the needs and justifiable expectations of the community. As the use of the principle of majority rule is not always feasible given the financial implications, the Emfuleni Department of Health and Welfare have to weigh and not count inputs according to the extent to which they can promote the general welfare of the public. In this case, voting can take place only in the Emfuleni Local Council after debates.

5.9.3 Solutions to the problem of community participation

Involvement of the community and community participation is not an easy process. People have their own fears, anxieties, prejudices, beliefs, and superstitions that need to be overcome. Masobe (1998) supports this view. In addition Vosloo (1991:260) argues that community participation is relatively low because many people do not engage in political party activity, join interest groups, or display interest in politics and administration. For implementing any program health officials in Emfuleni have to become part and parcel of the community concerned. Health workers must go to communities, understand their culture, discuss existing problems and suggest solutions to problems with the community's active involvement. (Khokar 1992:37.)

Since it may not be possible to enroll everyone's participation, it is essential to involve community

leaders from a wide spectrum such as politics, economics, religion, sport and education. These people, if well motivated, can lead the change process by involving the whole community. Small health committees comprising five members each should be formed. This is a long and time consuming process, but essential for the solicitation of people's involvement.

Health departments such as the Emfuleni Department of Health and Welfare should make it a point that the concept of primary health care services does not rest with the primary health care centers and clinics only but disseminates and becomes the real concern of the various community centers like schools, elected community representatives, religious and cultural institutions and youth activities (Khokar 1992:37). Different health workers must maintain good liaison with the community and must remain alert to encash any opportunity for community participation.

5.10 SUMMARY

The structure of the Emfuleni Local Authority as regards to primary health care is designed in such a way that services can be rendered following the district health system. Hospitals and clinics are important facilities of the district health system and they require finances and human resources to deliver primary health care services. Security is a problem encountered by public health facilities and impact negatively on primary health care service delivery. A solution to the problem of security could be the continuous assessment and revision of security measures. Furthermore, as the rate of urbanization increases the population in the Emfuleni Local Authority's area of jurisdiction requires the local authority to extend services beyond its capacity. The role of traditional healers must receive attention by all the spheres of government in order to enhance the primary health care package. Lastly, all sectors of the community in the Emfuleni Local Authority should be involved in the solution of all problems regarding primary health care.

CHAPTER 6

GOVERNMENTAL RELATIONS IN PRIMARY HEALTH CARE

6.1 INTRODUCTION

The National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare as described in the foregoing three chapters cannot function as separate entities in the making and implementation of primary health care policies. There has to be cooperation in the administration of primary health care between the departments of health on the aforementioned three spheres of government. It is for this reason that political and constitutional changes that occurred since 1994 in South Africa changed the nature of intergovernmental relations and led to interdepartmental collaboration and the creation of intergovernmental relation institutions in primary health care.

This chapter focuses on the characteristics of governmental relations in South Africa, the inter-departmental approach to primary health care, and intergovernmental relations that include institutions created for purposes of intergovernmental relations. These institutions are either statutory or non-statutory and they encounter problems in an attempt to function properly. For instance, committees of ministers and members of executive councils sometimes take decisions that are not binding on provinces such as Gauteng. Extra-governmental relations have been dealt with in chapter five through community participation and therefore it is not described in this chapter.

6.2 CHARACTERISTICS OF GOVERNMENTAL RELATIONS IN SOUTH AFRICA

Adlem and Du Pisani as quoted in Hattingh (1998: 19) classify governmental relations into three categories, namely intergovernmental relations or relations between governmental structures; intra-governmental relations or governmental relations between internal government structures on either of the three spheres of government such as the National Department of Health, and extra-

governmental relations or relations between a government structure and the community.

Furthermore, Hattingh (1998: 23-24 & 28-29) explains that inter-governmental and intra-governmental relations can be subdivided into vertical and horizontal relations. The foregoing classification is also applicable to governmental institutions established for primary health care services in South Africa. Within the context of this dissertation, governmental relations refers to the relationship between and within the National Department of Health, the Gauteng Provincial Department of Health, and the Emfuleni Local Authority's Department of Health and Welfare as well as their relationship with other departments and the institutions established to facilitate relations on the three spheres of government.

In addition, section 40(1) of the *Constitution of Republic of South Africa Act, 1996* provides that the South African government is constituted as national, provincial (Gauteng) and local (Emfuleni) spheres of government which are distinctive, interdependent and interrelated. Furthermore, section 41(1)(h) of the *Constitution of the Republic of South Africa Act, 1996* stipulates that the three spheres of government must cooperate with each another in mutual trust and good faith by fostering friendly relations, assisting and supporting one another, informing one another of, and consulting one another on matters of common interest and coordinating their actions and legislation with one another. The relations cited in the foregoing sections of the *Constitution of the Republic of South Africa Act, 1996* are crucial for the successful rendering of primary health care services.

Co-operative government means that the spheres of government (that is the National Department of Health, the Gauteng Provincial Department of Health, and the Emfuleni Department of Health and Welfare) are interdependent within the macro organizational structure of the South African State concerning primary health care. These three spheres must work together to ensure effective government in the whole and each of its parts pertaining to primary health care. Co-operative government recognizes the complex nature of government in modern society. For South Africa to meet its health challenges such as the spread of HIV/AIDS it has to:

- co-ordinate services such as primary health care to avoid wasteful competition and costly duplication,
- develop a multi-sectoral perspective on the interests of the country as a whole, and respect the discipline of national goals, and policies such as the district health system,
- settle disputes between spheres of government such as the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare constructively without resorting to costly and time consuming litigation,
- collectively harness all public resources for rendering services such as primary health care within a framework of mutual support, and
- rationally and clearly divide the roles and responsibilities between the spheres of government, so as to minimize confusion and maximize effectiveness. (Department of Constitutional Development 1997: 131.)

Section 56 of the *National Health Bill, 2001* makes provision for the inter-relationship between public health facilities such as clinics. If, for instance, a public health facility is not capable of providing the necessary treatment or care, a user must be referred by the public health facility concerned to an appropriate health facility. This arrangement, however, does not give members of the public the latitude to by-pass health facilities next to them. If, for instance, a patient in Sebokeng chooses to make use of a health establishment in Bophelong without a referral letter, the concerned user is required to pay a by-pass fee. The by-pass fee is, however, not applicable in emergencies.

6.3 INTERDEPARTMENTAL APPROACH TO PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICAN INTERGOVERNMENTAL RELATIONS

The interdepartmental approach to primary health care refers to the collaboration between departments of health and other non-health departments such as education on the national sphere of Government, the Gauteng Provincial Government and the Emfuleni Local Government. Interdepartmental collaboration and programs are necessary because preventable diseases such as HIV/AIDS affect every institution and therefore every institution should have something to offer

in primary health care services. Interdepartmental programs build the community's capacity to draw in government and private sector support and participation. However, local programs need strong support from the province including some basic resources (Gauteng Provincial Department of Health 1999: 7) such as finance and human resources.

Since primary health care takes as its point of departure the goal of development, the organization of a district around interdepartmental co-operation at national, Gauteng and Emfuleni local spheres of government can improve the rendering of primary health care services. Issues such as food, water, housing and sanitation are the joint concern of primary health care and other aspects of district committees. Such a district would be designed with attention to socio-economic issues, to make coherent economic sense, and to allow common planning of aspects of development (Zwarenstein and Barron 1992: 19) such as training.

There are substantial health benefits associated with improved services that can outweigh the costs incurred in providing such services. Investments in, for instance, better nutrition, portable water, sanitation, housing and education may well do as much or even more to improve the health status of the communities than investments confined to the health sector alone (Khokar 1992:45). Inadequate access to a sufficient supply of good quality of water and poor sanitation services creates increased risk of outbreak of diseases, with diarrhea being the most prevalent. Considering the relative costs and benefits of improved water supply and sanitation, the most important step is the provision of a suitable and properly functioning and managed service at clinic level. The provision of the foregoing basic services should provide the best value for money (Department of Constitutional Development 1999: 6)

With regard to energy, there are significant health benefits associated with the use of electricity rather than wood, coal, gas and paraffin. Furthermore, proper solid waste management also brings substantial health benefits. Waste accumulating in the Emfuleni informal settlements, for instance, generates odors and serves as a breeding place for rodents and flies. Solid waste may also block storm water drainage channels and pollute local sources of water. A well functioning storm water

drainage system is important from a primary health care perspective, particularly where settlement densities are higher as it is the case in townships found in Emfuleni. Without drainage, water stands in ponds where mosquitoes breed (Department of Constitutional Development 1999: 6) and there is a risk that children may play in polluted water.

Electricity supply, solid waste management and storm water control are the responsibility of the Emfuleni Local Authority. Although these services have a bearing on environmental health, their provision is not the responsibility of the Emfuleni Department of Health and Welfare. However, if the electricity and public works departments neglect the provision of these services, the Emfuleni Department of Health and Welfare will carry the burden of curing diseases which could have been prevented by delivery of services which make the environment to be healthier. Interdepartmental collaboration on functions which have a bearing on primary health care services should be coordinated by the Emfuleni Department of Health and Welfare as this Department can have an influx of patients if there is no cooperation in creating an environment which prevents diseases.

Contrary to the need for interdepartmental collaboration, health planning in South Africa has generally remained the responsibility of the health departments alone. Other sectors have traditionally regarded health as the business of the health department alone and see interdepartmental cooperation as a diversion of time and resources from their own targets and priorities. This is largely so because the system for development planning normally arranges activities vertically, neglecting horizontal links that can have a synergistic impact on development (Khokar 1992:45).

There are, for example, instances where well-planned hospital and clinic outreach programs fail because of lack of adequate water, electricity and public transport, amongst others. Furthermore, there are programs for drug addicts, the elderly, the disabled which require coordinated efforts concerning housing, education, vocational training and health teams (Khokar 1992:45). Transport in particular, is a problem encountered by clinics in the Emfuleni Local Authority (Motloba 1999).

The concept of primary health care rests on the conviction that the so-called non-health factors have

a direct effect on health. Educational programs, both formal and informal, have direct and indirect effects upon the health of the individuals and the community of Emfuleni in view of their changed knowledge, attitude and skills in managing their own health. Furthermore, in the promotion and improvement of health, housing is central in primary health care because amenities and facilities that go with it such as water and sanitation can take place. Other comforts like protection against heat, cold, insects and rodents are provided by a good home (Khokar 1992:45).

For primary health care services to be rendered effectively, there has to be a large degree of interdepartmental coordination. Many factors influencing health such as water and housing are not controlled by the health sector. The improvement of people's health in the Emfuleni area, for instance, requires some degree of joint intervention of various departments. A practical example of inter-departmental cooperation as regards to primary health care is the partnership between the health and education departments at the three spheres of government. Aids, for instance, is a problem that requires the departments of health and education to cooperate. (Planact 1997: 54.)

In agriculture, for example, crops, policies on taxes, producer subsidies and agricultural credits can to a large extent affect the shift in production and consumption away from health damaging to health promoting products. (Khokar 1992: 42.) For this to happen, the national Department of Health, Agriculture and Finance need to cooperate and make sure that health promoting agricultural products are known and consumed by people as a way of preventing diet related diseases.

NGOs have been excluded from planning, and often from information on health sector activities, whereas the private sector has been regarded as autonomous and not clearly a part of the health resources of the country or district. Traditional or alternative health practitioners have not usually been regarded as part of the health sector at all. This fragmentation should be dramatically reduced at the district level. The District Health Authority in Emfuleni, for instance, must have knowledge of, and channels of communication, with all of the agencies and actors mentioned above. This is not to say that the district health authority will be able to control these independent agencies, but full knowledge and shared planning could go a long way to improve trust and reducing irrationality and

waste (Zwarenstein & Baron 1992:20).

In the development of the district health systems in South Africa, the need for interdepartmental cooperation was taken into consideration. The National District Health System Committee agreed that the ideal district boundaries are those that permit social services delivery in a holistic, integrated manner such that social services which include, amongst others, health and education share the same boundaries. (South Africa: 1998b: 7.)

In all provinces, including the Gauteng Province, provincial district health system committees have been established as strategic and operational planning structures on which local governments such as Emfuleni are represented. Representation of other government departments is necessary to facilitate interdepartmental cooperation. The National District Health Systems Committee for instance, includes representatives from the Department of Welfare, the Department of Correctional Services, the South African Local Government Association and South African Medical Service. (South Africa 1998b: 7.)

6.4 INTERGOVERNMENTAL RELATIONS BETWEEN INSTITUTIONS RESPONSIBLE FOR PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICA

There are a number of intergovernmental institutions established specifically for coordinating primary health care related activities between the three spheres of government and departments of health. The subject matter of these relations relates to activities, programs, policy regarding functional areas such as primary health care that impact upon one or more spheres or departments of the government (Department of Constitutional Development 1999: 23). Primary health care, for instance, is a functional area that requires attention from more than one government department. Various intergovernmental institutions are described below. Diagram 8 below shows that intergovernmental institutions for primary health care in South Africa are created on national provincial and local spheres of government.

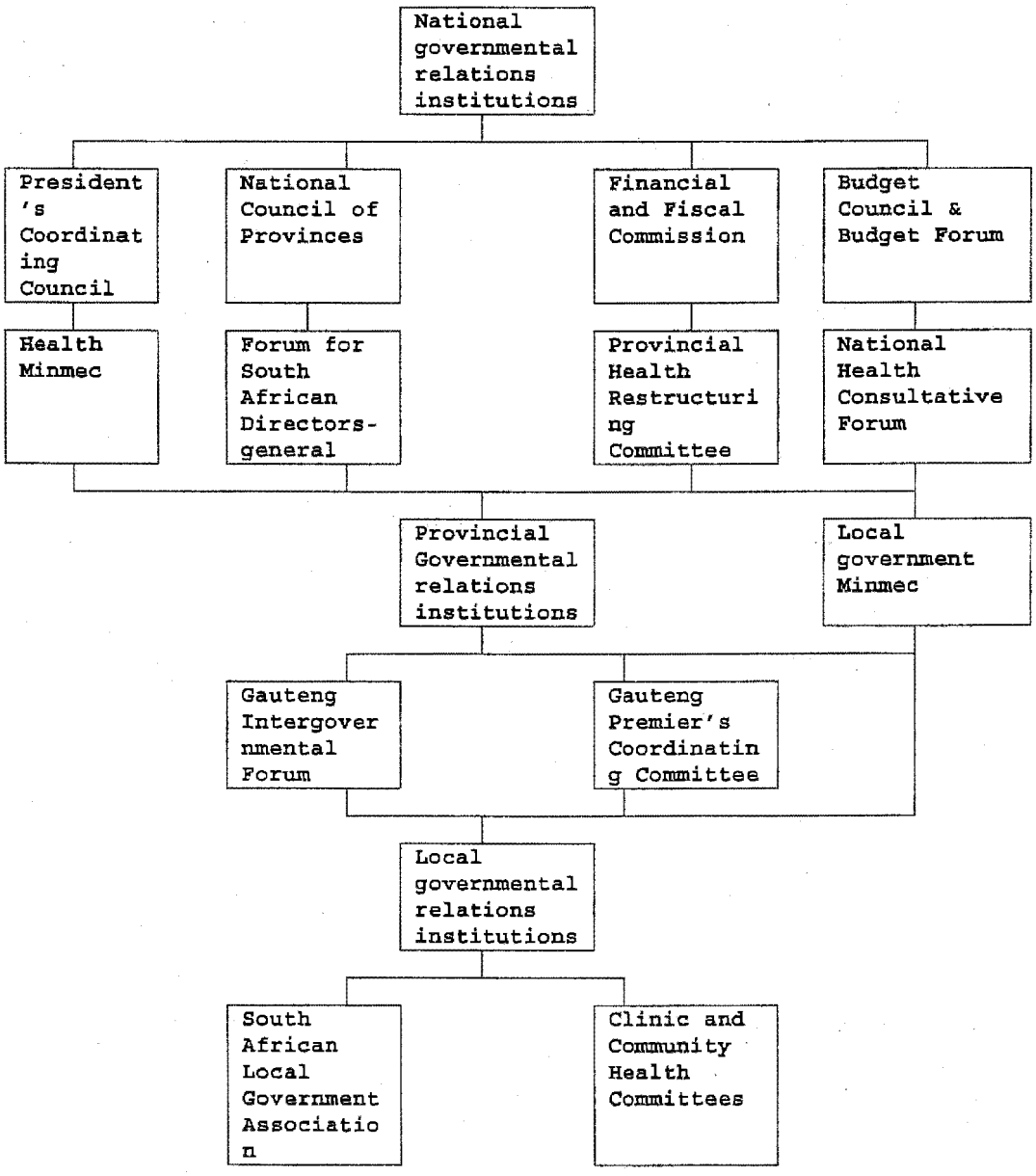

Diagram 8: intergovernmental institutions for primary Health Care

6.4.1 President's Coordinating Council

The highest office (that is, the President's Office) in the country plays an important role in intergovernmental relations. The President is the Chairperson of the President's Coordinating Council that comprises the Minister for the Department of Provincial and Local Government and

the nine premiers. The President's Coordinating Council, according to Reddy (2001:30), plays a pivotal role in planning, policy and legislation between provinces and other spheres of government. Its main focus areas are the development of provincial policy, preparing and initiating legislation for the provinces, the implementation of national legislation in the areas listed in schedules 4 and 5 of the *Constitution of the Republic of South Africa Act, 1996* and to promote the development of local government in accordance with section 155(7) of the *Constitution of the Republic of South Africa Act, 1996*. As primary health care services are also listed in the aforementioned schedules, it may also be discussed by the President's Coordinating Council.

6.4.2 National Council of Provinces

According to section 42(1) of the *Constitution of the Republic South Africa Act, 1996* Parliament consists of the National Assembly and the National Council of Provinces. The National Council of Provinces consists of ten delegates including the premier from each of the nine provinces including the Gauteng Province. To ensure that there is fair representation in parliament, section 67 provides for the participation of not more than ten part-time local government representatives designated by organized local government to represent the different categories of local authorities. The local government representatives can only participate when, for instance, the National Council of Provinces discusses a health bill that impacts on local authorities. Their participation is, however, limited as they are not allowed to vote. The National Council of Provinces can initiate or prepare legislation on a functional area as mentioned in schedule 4 of the *Constitution of the Republic of South Africa Act, 1996* such as primary health care.

Furthermore, Reddy (2001: 33) points out that the National Council of Provinces has some limitations in performing its duties. For instance, the National Council of Provinces does not challenge the policy assumptions of the national ministries such as health and does not allow the expression of distinctive regional interests.

6.4.3 Financial and Fiscal Commission

The Financial and Fiscal Commission is an independent statutory institution established in terms of section 220 of the *Constitution of the Republic of South Africa Act, 1996*. The Financial and Fiscal Commission is a permanent expert commission established to deal with intergovernmental fiscal relations in South Africa. It is an advisory body and has a mandate to make recommendations on financial and fiscal matters to Parliament and the provincial legislatures on matters such as the funding of primary health care and prioritization of the prevention of the spread of HIV in, for instance, the Gauteng Province. The Financial and Fiscal Commission can further be described as a separate institution from government and therefore is able to perform impartial checks and balances between the three spheres of government. It facilitates co-operative government on intergovernmental fiscal matters. In making its recommendations, the Financial and Fiscal Commission has to take into account, amongst others, the following:

- the needs and interests of provinces and that local authorities such as Emfuleni are able to provide basic services which includes primary health care and perform other functions allocated to them,
- the fiscal capacity and efficiency of provinces such as Gauteng and local authorities, and
- obligations of, for instance, the Gauteng Province and Emfuleni Local Authority in terms of national legislation such as the *Health Act, 1977*.

Furthermore, in terms of the *Intergovernmental Fiscal Relations Act, 1997 (Act 97 of 1997)* the Financial and Fiscal Commission may attend meetings of the Budget Council and the Local Government Budget Forum (www.ffc.co.za/overview/constitutional-mandate.html 2000).

6.4.4 Budget Council and Local Government Budget Forum

Apart from the Financial and Fiscal Commission described in the previous section, the Budget Council and the Local Government Budget Forum are established in terms of the *Intergovernmental*

Fiscal Relations Act, 1997. These two committees consist of the Minister of Finance (as Chairperson) and the MEC for finance in each province including the Gauteng Province. In addition to these office bearers, the Budget Forum has five representatives nominated by the South African Local Government Association and a representative nominated by organized provincial organizations such as Gauteng Association of Local Authorities. The aim of these two committees is to promote co-operation through consultation between the national, provincial, and local spheres of government on fiscal, budgetary, and financial matters and to prescribe a process for the determination of an equitable sharing and allocation of revenue raised nationally for purposes of primary health care and other services.

6.4.5 Inter-ministerial committees

The interdepartmental support program at the national sphere of government led to the establishment of an Interdepartmental Committee on HIV/AIDS in 1998. The Interdepartmental Committee on HIV/AIDS has representatives from all government departments and meets monthly to coordinate HIV/AIDS activities and programs. In addition, the Interdepartmental Committee on HIV/AIDS pursues advocacy goals and became increasingly an implementation structure for public awareness campaigns. Through the Interdepartmental Committee on HIV/AIDS it has been possible to establish departmental HIV/AIDS working groups, develop HIV/AIDS workplace policies, and conduct awareness programs for personnel. More than two million condoms as well as pamphlets and posters were distributed through this forum (South Africa 2000b: 13).

The interaction between the National Department of Health and the Department of Water Affairs and Forestry makes it possible to collect data, particularly chemical data on water quality. Furthermore, the involvement of environmental health practitioners in water catchment agencies is made possible by the cooperation between the National Department of Health and the Department of Environmental Affairs and Tourism. In addition, the cooperation of the three departments extends to health care and medical waste management at all the spheres of government as well as developing national health care management. This includes field trials which were conducted in 1999 on

hazardous-free gas and auto-combustion incinerators for the proper disposal of medical waste at primary health care facilities (South Africa 2000b: 22).

6.4.6 Committee of the minister and members of executive councils (minmecs)

Minmecs have emerged as institutions for intergovernmental cooperation. They exist in every area including health where competencies between provincial and national government are concurrent matters, forming a 'pivotal' part of South African intergovernmental relations system. Minmecs are not constitutionally prescribed but informal entities of intergovernmental relations based on mutual trust and cooperation (Department of Provincial and Local Government 1999:72).

Minmecs afford the two spheres, namely the National Department of Health, and the Gauteng Provincial Department of Health to interact in a variety of sectors including health and primary health care. Minmecs provide advice, identify problems, anticipate potential areas of conflict and determine short and long-term priorities. Furthermore, minmecs may be seen as forums at which representatives of various spheres of government in a specific functional area such as primary health care discuss policy, gain clarity on legislation and exchange experiences (Department of Provincial and Local Government 1999:73-74).

Minmecs are normally composed of the national minister and the nine members of executive committees of each province. Officials and specialists may attend on invitation if required. Stakeholders are invited depending on the agenda. Officials participate in an advisory capacity to the political role players. Meetings of minmecs are normally chaired by the minister responsible for a specific portfolio such as Health (Department of Provincial and Local Government 1999:73-74).

Minmecs that have a bearing on primary health care are the Health MINMEC and Local Government MINMEC. These two minmecs are described hereunder.

6.4.6.1 Committee of Minister of Health and Members of Executive Councils (Health MINMEC)

The Health MINMEC is a non-statutory structure that functions at the national, and the provincial spheres in the fields of health and primary health care. The Health MINMEC consists of the Minister of Health as Chairperson, two special advisors to the Minister of Health, nine provincial MECs for health, nine provincial heads of health departments, Director-General and two deputies (national), five representatives from South African Local Government Association and one representative from the South African Military Health Services. Officials from the departments of health are invited to the Health MINMEC when their expertise and knowledge on a particular topic is required. The main function of the Health MINMEC is to ratify national health policies and to issue a mandate for their implementation. (Provincial Affairs and Intergovernmental Relations Institute 2001: 99).

6.4.6.2 Committee of Minister of Local Government and Members of Executive Councils (Local Government MINMEC)

The Local Government MINMEC is established on the same basis as the Health MINMEC. Its members are the Minister of the Department of Provincial and Local Government, nine provincial MEC's for local government, heads of nine provincial local government departments, chief executive officer and office bearers of South African Local Government Association, the chairpersons of the nine provincial municipal associations of the South African Local Government Association, a representative of the Department of Finance, a representative of the Independent Electoral Commission, a representative of the Municipal Demarcation Board, the chairperson of the Portfolio Committee on Local Government, chairperson of the National Council of Provinces, and Chairperson of the Financial and Fiscal Commission. Other national government Departments attend on an *ad hoc* basis when a need arises.

The local government MINMEC serves as a forum through which the role players at all the three

spheres of government can consult with each other on the implementation of policies such as environmental health which requires inter-sectoral collaboration within local governments. Furthermore, the Local Government MINMEC is responsible for the following functions:

- to provide advice and assistance to national, provincial and local government;
- to identify potential problem areas such as the spread of polio and to contribute towards suitable and acceptable solutions;
- to determine priorities such as citizen participation for local government which should be addressed in the short, medium and long terms;
- to consider and make decisions regarding national and provincial legislation such as the *Health Act, 1977* which impacts on local government;
- to monitor the implementation of section 152 of the *Constitution of the Republic of South Africa Act, 1996* which sets out the objectives of local government;
- to discuss the capacity building programs that are provided in the various provinces and by the national government to local government; and
- to support and capacitate organized local government. (Provincial Affairs and Intergovernmental Relations Institute 2001: 100-1001).

Reddy (2001:32) further identifies weaknesses associated with minmecs. Minmecs do not have a clear and inclusive strategic agenda setting. In addition, Minmecs are dominated by the national ministers, members of executive committees sometimes do not have mandates from provincial executive committees, there is normally poor attendance of their meetings, their decisions are not binding, and they do not monitor the implementation of their decisions.

6.4.7 Forum for South African Directors-General

The Forum for South African Directors-General (FOSAD) is chaired by the Director-General in the Office of the President. Its members are the directors-general of the nine provinces and all the other national directors-general.

FOSAD is established to give technical and administrative support to the President' Coordinating Council. It also looks into crosscutting issues such as human resources development and health. It serves as a technical advisor to Cabinet committees and prepares reports for the Cabinet Lekgotla (Bosberaad) which takes place during January and July every year. It also makes recommendations to Cabinet regarding crosscutting issues (Provincial Affairs and Intergovernmental Relations Institute 2001: 94).

6.4.8 Provincial Health Restructuring Committee

The Provincial Health Restructuring Committee (PHRC) is composed of the Director-General, Deputy Directors-General of the National Department of Health, heads of the provincial health departments and the South African Medical Services. The PHRC is the highest management structure and supports the Health MINMEC with technical advice that may be used to make policy decisions. The PHRC has various subgroups to develop technical documents to underpin policy development and to diffuse the best practice. The Policy and Planning Sub-committee meets with provinces to ensure strategic planning coordination and to monitor the achievement of national priorities by the District Health Systems Committee, the National Hospital Coordinating Committee and the District Financing Committee (with national, provincial, and local government representation) (Abedian, Strachen & Ajam 1999: 37-38).

6.4.9 National Health Consultative Forum

The membership of the National Health Consultative Forum (NHCF) include national and provincial departments of health, professional associations, trade unions, the private sector, statutory bodies and NGO's. The NHCF is intended to advice the National Department of Health on issues affecting civil society (Abedian et al. 1999: 38).

6.4.10 Gauteng Intergovernmental Forum

The Gauteng Intergovernmental Forum convenes twice a year and is composed of the following members,

- the Gauteng Premier as Chairperson,
- members of the Gauteng Provincial Executive Council,
- heads of departments in support of politicians/ senior management,
- all mayors,
- members of the mayoral committees, and
- municipal managers

The function of the Gauteng Intergovernmental Forum is to facilitate integrated planning and development for the province. Through the Forum, members are able to exchange information about the respective programmes of the provincial and local government spheres with a view to get a clearer understanding of strategic priorities and the complementary priorities of the local and provincial government spheres. The Gauteng Intergovernmental Forum further creates an environment for joint commitment and collaboration, continued engagement and co-ordination where appropriate (Provincial Affairs and Intergovernmental Relations Institute 2001: 109).

6.4.11 Gauteng Premier's Coordinating Committee

The Gauteng Premier's Coordinating Committee is chaired by the Premier and its members are the MEC for Development Planning and Local Government and the head of that Department, three metro executive councils, and three district mayors and their respective municipal managers including a delegation from the Emfuleni Local Authority.

The function of the Premier's Coordinating Committee is to coordinate the delivery of services such as primary health care and it serves as a structure for consultation and collaboration between the local and provincial spheres of government and the establishment of a synergy between the programs

for provincial and local government spheres (Provincial Affairs and Intergovernmental Relations Institute 2001: 109-110).

6.4.12 South African Local Government Association (SALGA)

The South African Local Government Association is established in terms of the *Organized Local Government Act, 1997 (Act no 52 of 1997)*. Its membership consists of the Chairperson, Deputy Chairperson, and representatives of local government associations.

According to Reddy (2001:33-34) the SALGA has a multiple points of function of influencing the direction and content of the national policy on local government. Its main functions are to:

- consult the Minister of Provincial and Local Government in cases concerning national and provincial affairs involving local government issues;
- approach any minister to consult with the national government;
- nominate persons for appointment by the President as members of the Financial and Fiscal Commission; and
- designate not more than ten persons from the provincial nominees to participate in the National Council of Provinces (Provincial Affairs and Intergovernmental Relations Institute 2001: 99).

6.4.13 Clinic and Community Health Center Committees

Section 54 of the National Health Bill, 2001 makes provision for the establishment of clinic and community health center committees. Membership of these committees include local government councilors, members of the community served by the clinic, persons with expertise in legal and financial matters, the head of the clinic and any other person designated by the Member of the Executive Council responsible for Health in Gauteng. The Emfuleni Local Department of Health and Welfare already has committees called health forums.

6.5 INTRA-GOVERNMENTAL RELATIONS

The definition of intra-governmental relations provided in section 6.2 of this chapter describes intra-governmental relations as relations between internal sections of government departments. For purposes of this dissertation, intra-governmental relations refers to the relations which exist within the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Local Department of Health and Welfare respectively.

The relations between the aforementioned spheres of government are clearly provided for in Chapter 3 of the *Constitution of the Republic of South Africa Act*, 1996. However, despite all these arrangement to enhance inter-governmental relations, intra-governmental relations receives little attention in various acts of Parliament such *Organized Local Government Act, 1997.* This implies that departments of health on the three spheres of government under consideration have to rely on the initiative of their managers to bring about intra-governmental relations.

The negligence of intra-governmental relations can have undesirable consequences on the delivery of primary health care services by the Emfuleni Department of Health and Welfare. For example, Madonsela (1999) mentions the assumption of some functions which were previously within the jurisdiction of hospitals by clinics as a problem which is caused by insufficient internal coordination and communication with the Emfuleni Department of Health and Welfare.

Another anomaly cited by Motloba (1999) is the centralization of decision-making authority. If facility managers at clinic level do not have the authority to decide, they have to refer every minor problem regarding primary health care within their area of jurisdiction to the Head of the Emfuleni Department of Health and Welfare and thereby wasting time. Furthermore, it is impossible to expect a facility manager to account for decisions that they were not part of.

For intra-governmental relations to yield positive results for primary health care, the managers of health departments need to delegate more decision-making authority to their regional offices,

hospitals and clinics while maintaining regular contact with the concerned decision-makers. Delegation of authority should be coupled with training to ensure that decision-makers know exactly what they are doing.

An alternative to delegation of authority in intra-governmental relations is to establish managerial committees that include top managers such as the Director-General of the National Department of Health and managers at regional offices. The same arrangement could be made for Gauteng Provincial Department of Health as well as the Emuleni Department of Health and Welfare. These committees could be important for consultation on primary health care policy and its implementation.

6.6 SUMMARY

Although a number of problems exist in governmental relations in South Africa, improvements in governmental relations have been brought by the *Constitution of the Republic of South Africa Act, 1996*. The inter-departmental approach needs more attention as the efforts of the departments of health on the three spheres of government alone will not live up to the quest for a healthy South African nation. South Africa has enough inter-governmental relation institutions to facilitate the implementation of primary health care. However, non-statutory institutions are beset with problems that can be resolved by formalising them through legislation. Intra-governmental relations require even more attention as its negligence impact directly on primary health care service delivery. The next chapter shed some light on the practical steps that can be followed in solving problems highlighted in this dissertation.

CHAPTER 7

SUMMARY, FINDINGS AND RECOMMENDATIONS

7.1 INTRODUCTION

This is the last chapter of the research report on an investigation into the administration of primary health care in South Africa that focuses specifically on the Emfuleni Local Authority. This chapter provides summaries of chapters one, two, three, four, five and six. Furthermore, this chapter outlines the findings of the research and the recommendations which address dysfunctional situations identified during the investigation of the administration of primary health care in the National Department of Health, the Gauteng Provincial Department of Health, and the Emfuleni Department of Health and Welfare.

7.2 SUMMARY

The purpose of this section of the dissertation is to provide a summary of all the preceding chapters. Chapter one is an introductory chapter. It provides a statement of the problem and a background to the problem areas that have been identified in the administration of primary health care services in the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. Furthermore, in chapter one, the objectives of the study, which mainly focus on solving problems that exist in the area of primary health care, are outlined. The significance of the study as indicated in chapter one is to contribute to public administration as a field of work through the suggestion of possible solutions to the problems in the administration of primary health care services in the Emfuleni Local Authority. It is also hoped that this research report will increase the literature on the administration of primary health care.

To investigate the problem areas identified in chapter one and achieve the objectives outlined above, the researcher had to use a particular method. The survey method was followed in the gathering of

data from primary and secondary sources. The normative approach was adopted in the processing and interpretation of data.

As this dissertation is a scientific document, specific reference method was chosen and used. The author used the Harvard reference method to acknowledge primary and secondary sources of information. The Harvard reference method is further used in the compilation of a list of sources which appears at the end of this dissertation. To comply with the Harvard reference method, the list of sources is compiled in an alphabetical order. For example, details of a book acknowledged in the text appear in the list of sources as follows: author's surname, comma, author's initials, full stop, ed. (In the case of an editor), date of publication, full stop, complete title of the book (underlined), full stop, place where published, colon, publisher (abbreviated), full stop.

Time and other constraints could not allow the author to cover every aspect of primary health care hence chapter one outlines the restrictions on the study. The study took place within the framework of public administration and in particular focussed on the administration of primary health care services and the involvement of international, regional and sub-regional health institutions, the National Department of Health, the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. Governmental relations between the above-mentioned three spheres of government are also the focal area of the study. Furthermore, in an attempt to facilitate the understanding of this dissertation, terminology, phenomena and acronyms are explained. Lastly, the sequence of chapters is outlined chapter one.

The second chapter focuses on the international perspective of primary health care. The influence of international health and related institutions is described in this chapter. These institutions are classified into international (universal) institutions such as the WHO, international (regional) institutions such as the African Union and international sub-regional institutions such as SADC.

Institutions whose influence on primary health care in South Africa is investigated include the United Nations, the World Health Organisation, Commonwealth of Nations, the International

Hospital Federation, the African Union and the Southern African Development Community.

The national sphere of government in South Africa is the focal area for investigation in chapter three. This chapter begins with the historical development of primary health care services in South Africa. The historical development traces the origin of primary health care to the Karks family at Pholela Health Centre in Natal in 1940 and the 1978 Alma Ata Declaration.

Furthermore, two approaches, that is the benefit-received and ability-to-pay approaches are described as options for the delivery of primary health care services in South Africa. The ability-to-pay approach is used in South Africa since the announcement of free primary health care in 1994. The number of people who cannot afford to pay for health care services is the main reason for the implementation of the ability-to-pay approach.

The national perspective on primary health care further focuses on the influence of legislation approved by Parliament on primary health care, as well as the financing of primary health care services by the National Government. The merits and demerits of the reduction of personnel of the National Department of Health are also described.

In chapter four the field of study is narrowed down to the provincial sphere of the Gauteng Province. This chapter describes the role of the Gauteng Provincial Department of Health in the administration of primary health care services. Chapter four further describes the implementation of the district health system by the Gauteng Provincial Department of Health.

In addition to the foregoing, chapter four also describes five approaches to health promotion. The five approaches include medical approach, behavioural change approach, educational approach, empowerment approach and social change approach. From the discussion of these approaches, it could be inferred that they are complementary. This implies that one approach is not entirely independent from other approaches.

Corruption and theft form part of the aspects covered in chapter four as these phenomena have financial implications for the Gauteng Department of Health. The impact of corruption and theft has the same undesirable effects on the National Department of Health and the Emfuleni Department of Health and Welfare.

Chapter four further describes the role of the private sector and non-governmental organisations in the administration of primary health care. The participation of the private sector and non-governmental organisations is important as the government does not have the financial, human and technical capacity to deliver primary health care services to all people in the Gauteng Province and the Emfuleni Local Authority's area of jurisdiction.

Chapter five focuses on primary health care services provided by the Emfuleni Local Authority. This chapter puts the Emfuleni Department of Health and Welfare in perspective as the lowest sphere responsible for the delivery of primary health care services. Chapter five further describes the role of hospitals and clinics in the rendering primary health care services. The financing of primary health care service, personnel, security, urbanisation, the role of traditional healers in rendering primary health care services and community participation are problem areas investigated and described in chapter five.

Chapter six focuses on governmental relations in the administration of primary health care services. In chapter six a description of the characteristics of governmental relations in the new South African constitutional dispensation is presented. Interdepartmental approach to the administration of primary health care services in the South African primary health care sector emphasises relations between public institutions which focuses on different areas of service delivery.

Intergovernmental relations institutions for primary health care services in South Africa are also described in chapter six. The description concentrates on statutory and non-statutory institutions facilitating relations between the National Department of Health, Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare. Institutions described in this chapter

include the President's Co-ordinating Council, the National Council of Provinces, the Financial and Fiscal Commission, Budget Council and Local Government Budget Forum, Inter-ministerial committees such as the Health Minmec and the Local Government Minmec, Forum for South African Directors General, Gauteng Premier's Co-ordinating Committee, South African Local Government Association, clinic and community health centre committees in the Emfuleni Local Authority.

7.3 FINDINGS

At the end of an investigation into the implementation of primary health care services in South Africa with specific reference to the Emfuleni Local Authority in Gauteng, the following findings were made:

- International institutions and international health institutions in particular originate from agreement entered into by member states.
- International institutions formulate policy guidelines on health and primary health services in particular. However, their policy guidelines cannot be imposed on South Africa or any sovereign state without the particular government's consent.
- Membership of international institutions do not come free, every member state including South Africa has to contribute to the finances of these institutions.
- Institutions active in the international sphere of primary health care can be classified into international (universal) institutions such as the UN, international-regional and international sub-regional health and related institutions.
- Among the three categories of international health institutions mentioned above, the WHO appears to be dominating in the international sphere of primary health care. Regional and sub-regional institutions such as the African Union and SADC are closer to South Africa and therefore they are expected to play a significant role in the improvement of the administration of primary health care services. However, these institutions seem to be concentrating on political and economic issues while primary health care issues are seldom given the attention they

deserve.

- The aim of the WHO of ensuring "health for all by year 2000" was a utopia. This finding is informed by the number of people who continue to be infected, affected and die in South Africa and in particular the Gauteng Province and in the Emfuleni local authority's area of jurisdiction as a result of HIV/AIDS after year 2000.
- International health and related institutions such as the WHO can assist developing countries such as South Africa. South Africa was assisted with finance for the improvement of legislation on the administration of primary health care services.
- Although internationally the primary health care concept can be traced to the Alma Ata Declaration in 1978, South African attempts to implement primary health care date back to the 1940s and 1950s. However, these attempts were never successful as a result of the reluctance of the then government-of-the-day to accept the primary health care approach at that stage.
- The benefit-received approach and the ability-to-pay approach to rendering primary health care services can be followed by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare depending on the ideology of the political party in power and the economic position of the majority of citizens in a country such as South Africa.
- Health policies approved by the National Government and the National Department of Health in particular must be implemented by all provincial departments of health including Gauteng Provincial Department of Health and local departments of health such as Emfuleni Department of Health and Welfare.
- Parliament plays an important role in the allocation of funds to the National Department of Health for purposes of implementing primary health care policies on the three spheres of government.
- As regards to personnel, the National Department of Health had to deal with supernumerary personnel from the former four provinces, four independent states and six self-governing territories of the past political dispensation in South Africa. A strategy for the reduction of the size and number of personnel was necessary hence personnel were offered voluntary severance packages. This exercise had both positive and negative impact on the Department of Health. Positive effects were the financial saving of R9, 8 Million. The negative effects were the loss

of skilled personnel.

- Provinces such as Gauteng and its Department of Health are responsible for the implementation of the district health system. The implementation of the district health system in the Gauteng Province and the Emfuleni Local Authority is still in its infancy stage.
- There were problems with the transfer of personnel from the Gauteng Provincial Department of Health to the Emfuleni Local Authority. These problems were mainly the result of uncooperative personnel who were fearful of the new situation.
- Health promotion is found to be an enabling mechanism for people to increase control over and improve their health. It is an important component of primary health care as it focuses on the prevention of diseases.
- To disseminate information regarding primary health care as part of the health promotion strategy, various techniques can be used. These techniques include leaflets, pamphlets, flipcharts, posters, large banners, health exhibits, videotapes, public address systems and closed circuit television.
- Radio and television are effective ways of communication as they can be used to cover a larger audience including illiterate people.
- Educational institutions such as schools in the Emfuleni Local Authority's area of jurisdiction are found to be important centres for health promotion, however they are still not used effectively.
- The medical, behavioural, educational approaches are found to be complementary in the health promotion efforts.
- Corruption and theft have a negative impact on the finance and the health of patients as medicines stolen lead to the under-supply of medication to patients who solely rely on public health facilities.
- The private sector and non-governmental organisations' full potential to contribute in primary health care has not yet been fully tapped and therefore need to be engaged by the three spheres of government investigated in this dissertation.
- Decision-making in the Emfuleni Department of Health and Welfare is centralised. Clinic managers do not have much say in matters such as budgeting.

- There was no proper co-ordination and communication when some services were decentralised from hospitals to clinics. This situation led to unfunded mandates.
- Lack of transport hampers home and school visits and thereby limiting accessibility of primary health care services to people who cannot visit the clinics as a result of being sick.
- Personnel shortages impact negatively on primary health care service delivery especially when some nurses have to attend courses, are on study, sick or vacation leave.
- Burglaries and theft lead to the loss of important equipment such as refrigerators, heaters and medicines thereby inhibiting the administration of primary health care services by hospitals and clinics.
- Urbanisation and the increase of population puts a strain on the ability of the Emfuleni Local Authority to render effective primary health care due to limited financial, and human resources.
- Traditional healers are still sidelined in the rendering of primary health care. As a result traditional healers do not make a meaningful contribution towards primary health care services in the Emfuleni Department of Health and Welfare,
- Community participation is an important element of a democratic government especially at the local sphere of government such as Emfuleni Local Authority. However, apart from elections, people seem to ignore their obligation to participate in the process of policy-making for the administration of primary health care services.
- A number of obstacles that hamper community participation have been identified. These obstacles include, amongst others, professional resistance, passivity of communities, lack of strong political will, lack of management/administration and communication skills, lack of logistical support and co-ordination mechanism, lack of innovation and conflict of interest in community participation.
- The three spheres of government described in this dissertation cannot function separately in the rendering of primary health care services hence governmental relations is emphasised. Minmecs cannot function effectively as they are non-statutory institutions. Provinces and local authorities such as Gauteng and Emfuleni can easily ignore their decisions.

7.4 RECOMMENDATIONS

In view of the arguments presented in the foregoing chapters of this dissertation and the findings described in this chapter, the following recommendations are made:

- While the SADC or the OAU as the AU's predecessor have not been actively involved in the health sector activities in the past, both these institutions have many years of experience in the region and can provide an authentic and indigenous approach to regional co-operation. These institutions are in a better position by virtue of their knowledge about problems in the African and Southern African region in particular. It is important for them to play an active role and collaborate with universal health institutions such as the WHO.

- It is unfortunate that there is no line of demarcation regarding the responsibilities of the international, international-regional and sub-regional health institutions. It could, nonetheless, be appreciated if the AU can gear itself to play a significant role by making sure that its Committee on Health, Labour and Social Affairs focuses on primary health care. This Committee must include experienced health officials in an advisory capacity. A continuous dialogue between ministers of health who represent AU member states with other international institutions such as the WHO could help to clarify the role of the AU's Committee on Health, Labour and Social Affairs regarding primary health care. The dialogue can be in the form of a conference attended by delegates from all international health institutions involved in primary health care. This could lead to the co-ordination and the reorganisation of these institutions' functions in order to avoid duplications and overlap of functions.

- The SADC should, despite its original economic objectives, be more involved in the improvement of the administration of primary health care services in South Africa and other member states. The SADC could organise seminars, conferences and workshops on primary health care for its involvement to be more visible. These efforts will be in line with the commitment of the WHO and South Africa to primary health care. Assistance in finding

solutions to problems encountered by the National Department of Health, the Gauteng Provincial Department Health, and the Emfuleni Department of Health and Welfare including in the administration of primary health care should be seen by the SADC and all its member states as a stepping stone towards the achievement of its original objectives of economic prosperity. Primary health care, with its emphasis on prevention, should form the basis for economic prosperity because the spread of diseases such as AIDS could have adverse consequences for member states such as South Africa. The importance of primary health care in economic prosperity implies that the original objectives of the SADC need to be reviewed in order to ensure that its mission is adapted to the existing problems in the administration of primary health care services in South Africa and other member states.

- Although institutions such as the AU and SADC have committees on health, it is still necessary for these institutions to pay more attention to primary health care and if need be, establish sub-committees on primary health care.

- The loss of personnel as a result of voluntary severence packages offered to personnel by the National Department of Health and the Gauteng Provincial Department of Health as well as the loss of doctors and nurses to foreign countries by local authorities such as Emfuleni will have negative consequences in the near future. The importation of foreign doctors from countries such as Cuba has partly addressed the shortage of doctors and nurses in South Africa. However, the importation of doctors should only be seen as a temporary solution as there is no guarantee that foreign doctors will stay on in South Africa. For this reason, it is important for the aforementioned spheres of government to accelerate training of nurses and doctors in South Africa. Bursaries, can for instance, be offered to students in order to attract more people to the health professions.

- In addition to attracting more students through bursaries, the condition of service of doctors and nurses need to be improved within the constraints of the financial resources of the public sector. It is also necessary for the National Departments of Health, Gauteng Provincial Department of

Health and the Emfuleni Department of Health and Welfare to conduct exit interviews for doctors and nurses who are leaving the public health sector for the private sector or foreign countries. Exit interviews will assist health managers to establish the reasons for the high personnel turnover in the public health sector and to devise new strategies to minimise resignations.

- For purposes of personnel development, it is necessary for nurses and doctors to attend compulsory and regular courses in order to keep abreast with the latest developments and harness their skills. Furthermore, clinic managers have an important role to play in primary health care service delivery hence their managerial skills also need to be improved through training. To ensure that facility managers perform functions effectively, they have to sign performance contracts. Performance contracts will enable local authorities such as Emfuleni to remove clinic managers who do not show any sign of improvement after training and having followed the provisions of the *Labour Relations Act, 1995 (Act no 66 of 1995)*.

- Another area that needs training and workshops is the implementation of the district health system by the local authorities such as Emfuleni. Workshops will enable all those involved in the implementation of the district health system to share ideas and best practices that can in turn assist the Emfuleni Department of Health and Welfare.

- The transfer of personnel from the Gauteng Provincial Department of Health to the Emfuleni Department of Health and Welfare should be done after consultation with the concerned personnel particularly when such transfers involve physical relocation. If possible, personnel should volunteer to be transferred and be given all the necessary information regarding the implication of their transfer. The transfer of personnel from the Gauteng Provincial Department of Health will alleviate the shortage of personnel such as doctors and nurses in the Emfuleni Department of Health and Welfare.

- Health promotion is an integral part of the administration of primary health care services. Health

promotion should not be seen as a function of doctors and nurses only. It has to include teachers and any other member of the community in the Gauteng Province and the Emfuleni Local Authority who can read and disseminate information regarding the prevention of diseases such as HIV/AIDS. In addition to the dissemination of information through a word of mouth, a number of techniques can be used. As already mentioned in chapter four, techniques for the dissemination of information include leaflets and pamphlets. The advantage of these techniques is that the information they provide cannot be easily distorted as it is likely to happen with the grapevine.

- Corruption and theft are an indication of moral degeneration in the South African and the Emfuleni Local authority's society in particular. To curb this moral vice, public health officials should attend workshops that focus on the negative impact of corruption and theft. Furthermore, a system of whistle blowing should be strengthened. It should reward those who expose the perpetrators of theft and corruption.

- The private sector and the NGO's must be seen as partners and not competitors in the rendering of primary health care services in the Gauteng Province and the Emfuleni Local Authority's area of jurisdiction. There should be continuos sharing of ideas and joint ventures involving the Gauteng Provincial Department of Health and Emfuleni Department of Health and Welfare in areas such as the prevention of infectious diseases that include HIV/AIDS.
- There is a need for the decentralisation of decision-making from the Head of the Emfuleni Department of Health and Welfare to clinic managers in the Emfuleni Department of Health and Welfare. Furthermore, co-ordination and communication should be improved between hospitals, clinics and their managers particularly when new policies are made and implemented.

- Although the development of the western and traditional medicine took place separately for a long time in South Africa, traditional healing needs to be included in the administration of primary health care services. Traditional healers in Sharpville and Sebokeng for instance, need to be in continuous contact with nurses to learn about health promotion. Training can also be

arranged for traditional healers as most of them still follow a curative approach to primary health care despite the preventive approach advocated by the 1978 Alma Ata Declaration of the WHO.

- For purposes of democracy, community participation is important in South Africa and particularly in the Emfuleni Local Authority where the government is closer to the people. Officials in the Emfuleni Department of Health and Welfare have to experiment on a number of techniques through which apathy can be reduced. Techniques that can be experimented upon include public hearings, community advisory councils, panel discussions as well as surveys. If, for instance, the Emfuleni Local Authority needs the opinions of its community on effective administration of primary health care, questionnaires can be posted to members of the public together with their electricity bills. Such questionnaires should not ask questions regarding the identity of respondents. However, in this case, there is no guarantee that a representative sample of questionnaires will be returned. To ensure that questionnaires are returned, incentives such as one- percent discount in the bill payable in a particular month can be introduced.

- Community participation should not amount to window dressing, but citizens must see their inputs being put into practice where possible. Implementation of suggestions made by the public will reinforce participation in future.

- Governmental relations has been provided for in chapter 3 of the *Constitution of the Republic of South Africa Act, 1996*. Institutions such as minmecs established in accordance with the provision of the foregoing legislative measure tend to be ineffective if they function informally. This state of affairs implies that there is a need for legislation that formalises informal inter-governmental relations institutions such as the Health Minmec.

7.5 SUMMARY

In the foregoing chapter, a summary of the preceding six chapters has been outlined. In addition, the findings of an investigation into the administration of primary health care services in South Africa with specific reference to the Emfuleni Local Authority are presented. To complement the findings, a number of recommendations are made. It is hoped that these recommendations will add to the attempts by the Gauteng Provincial Department of Health and the Emfuleni Department of Health and Welfare to improve the delivery of primary health care services in their respective areas of jurisdictions.

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